UNNATURAL MOTHERS:

Nineteenth Century Understandings of Puerperal Insanity at Dix Hospital

Hannah Frisch

A thesis submitted to the faculty at the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Bachelor of Arts in the Department of American Studies in the College of Arts and Sciences.

Chapel Hill

2019

Approved by:

Robert Allen (Thesis Advisor)
Department of American Studies

Michelle Robinson
Department of American Studies

Tim Marr
Department of American Studies

Table of Contents.

Acknowledgements

Thank you to Dr. Robert Allen, for offering to be my advisor on my thesis. For trusting me to jump into a rabbit hole of research and offering guidance along the way. Throughout my undergraduate career, he has also been a mentor on all things American Studies and historical research.

Thank you also to Dr. Robinson and Dr. Marr for their willingness to read my thesis and offer insights. Your questions helped me step back and recognize my positionality in my research.

Thanks to the Community Histories Workshop team. For introducing me to the greater digital humanities project and your willingness to answer questions throughout my research. A special thanks to Sarah Almond who has been endlessly encouraging and insightful in both my research and my future plans.

I am forever indebted to Dr. Berlinger and the gals in the American Studies and Asian Studies seminar. It has been an amazing year working in a classroom of some inspiring and intelligent women. Through shared stress, countless pep talks, and cheese and crackers, I couldn't have completed this without you.

Thanks to my friends who listened to me excitedly share historical findings in the living room and nodded encouragingly at my excited and nerdy exclamations. I promise I wasn't avoiding you and will hang out with you now that this is turned in.

A huge thanks to my family who has always been my biggest fan club. For reading drafts and always being interested in my research, and for your patience and perpetual support. Thanks a bunch and I love you lots.

Abstract

Dorothea Dix Mental Hospital in Raleigh, NC operated as the state's first and primary insane asylum. The Community Histories Workshop has been conducting a historical research project using archival material from the State Archives of North Carolina to study the asylum and its admitted patients. My thesis focuses on the female patients admitted to Dorothea Dix Mental Hospital and questions why gendered language was often used in their diagnosis of insanity when these language distinctions were not made for men. The transcription and study of the two unique primary source documents, the Dix Hospital patient admission ledger and the general case books, act as my core evidence. Secondary literature provides a frame to view how these female patients fit into the larger context of mental illness at the time. Through a specific focus on women diagnosed with "puerperal insanity," I study the trends in the transcribed qualitative data of the women at Dix Hospital with this diagnosis. I also conducted case studies on two patients with puerperal insanity to understand their lives outside the hospital and potential social influences of their mental illness. My thesis aims to understand the concepts of insanity, femininity, and maternity during the turn of the century and how the female patients at Dix Hospital are situated in this historical context.

Introduction

Background

Advocacy for more humane treatment for people with mental illness grew in the nineteenth century. In particular, these humanitarian efforts focused on the establishment of public insane asylums. Nineteenth century doctors advocated for these public asylums because of their belief that the removal of the person from the social setting in which they were suffering would be the best and most effective treatment for the mentally ill. The asylum superintendents, as they were called, pioneered the new medical specialty of psychiatry.

North Carolina was the last of the original thirteen states to address the problem of mental illness.[1] Those with mental illnesses in North Carolina were subject to poor houses, jails, or the care their family could provide at home. In 1848, Dorothea Dix, the country's leading advocate for better treatment of the mentally ill, visited North Carolina. She identified its lack of treatment facilities for people with mental illnesses as a major problem that required immediate attention. After eight years of political and social lobbying by Dorothea Dix, the North Carolina Hospital for the Insane, often referred to as "Dix Hill,"[2] opened its doors to its first patient.[3] It was the state's first and principal insane asylum from 1856 to 2012.

After 156 years of operation, Dix Hospital closed its doors in 2012, and the last patients were transferred to a medical facility in Butner, NC.[4] The state of North Carolina sold the 306-

[1] Marjorie Lehman O'Rorke, *Haven on the Hill: A History of North Carolina's Dorothea Dix Hospital* (Raleigh: Office of Archives and History, 2010), 1.
[2] The name of the asylum changed several times since it opened its doors to patients. Its final name was Dorothea Dix Hospital in honor of Dorothea Dix in 1959. I will refer to the hospital in this paper as "Dix Hospital."
[3] O'Rorke, *Haven on the Hill*, 10.
[4] Harry McKown, "Dorothea Dix Hospital," NCpedia, last modified 2006. Accessed April 02, 2019, https://www.ncpedia.org/dorothea-dix-hospital.

acre property to the City of Raleigh in 2015. The city committed to use the site as a public park. An ambitious two-year planning process followed, which was approved by the Raleigh City Council on February 22, 2019.

The Community Histories Workshop is a team of faculty, undergraduate and graduate students, and staff that "works with local communities to recover, preserve, and share the memories, stories, and materials that reflect the multi-layered histories of place."[5] The CHW practices community archiving in historical spaces, involving and voicing the individuals in the local communities to share their stories. Practicing digital humanities, public history, archiving, and historical research, the CHW is a team dedicated to the unearthing and preservation of local memory through community engagement.

Community Histories Workshop is currently partnering with the Dix Park Conservancy Board's Legacy Committee and the City of Raleigh to recover the material history of the site so that it might inform planning for the park.

Initial research efforts focused on the records of Dix Hospital held by the State Archives of North Carolina. In June 2017, a set of leather-bound volumes was discovered by an archivist amongst the unprocessed material in the Dix Hospital collection. These ledgers contained each patient admitted to Dix Hospital in the order of their admission, starting with the first patient on February 22, 1856. The ledgers are arranged in rows and columns. Each record contains twenty fields of information (see Table 1 in Appendix). In addition to information about the patient at the time of admission – age, marital status, occupation, residence– the ledger follows the patient to their discharge or death.

[5] "About Us," Community Histories Workshop, accessed April 16, 2019, https://communityhistories.org/about/

Due to a change of the North Carolina Public Records Law in 2016, state records created more than one hundred years ago were made available to the public including the patient admission ledger and other patient-identifiable records from Dix Hospital. Due to this recent change in legal accessibility of these documents in the State Archives of North Carolina collection, the patient admission ledger and other Dix Hospital material have had limited or potentially no examination by previous researchers. Therefore, the change in the North Carolina Public Records Law opened up the opportunity for research for the CHW with materials that have had limited to no previous use by the public.

A major focus of this work was the transcription of the patient admissions ledgers and the creation of the first comprehensive, searchable database for a nineteenth century public insane asylum in the United States. As a member of the Community Histories Workshop, I have been transcribing the ledger to study both individual stories of patients and the categorization and description of various forms of mental illness to gain an understanding of the history of mental illness in North Carolina.

Another document, the general case book, was found in the State Archives of North Carolina a few months after the discovery of the patient admission ledgers. The general case book contains page-long histories of each patient on the day of their admission. Currently available from 1887-1918, they contain a report of the patient's family history, personal history, physical description, manifestations of the mental illness, behaviors, qualitative attributes, and longer notes of the patient's progress and treatment during their time admitted to the hospital (see Table 2 in Appendix). The general case books record qualities that individualize the patient and specify how their illness manifested. While the patient admission ledger spreadsheet enables

finding commonalities between the patients, the general case book describes the individuality of each patient.

The field that had continued to interest me in these two sets of records was the "supposed cause," especially those relating to female patients. Asylum superintendents believed that an "attack" of insanity occurred when a psychologically vulnerable person suffered a traumatic event or condition, termed the "supposed cause." Examples of these supposed causes include "sunstroke," "domestic troubles," "financial worry," and "the War."

The Form field in the patient admission ledger and the Diagnosis field in the general case book noted the general category of insanity from which the patient suffered. The number of forms was much more limited than supposed causes. The most common were mania, dementia, and melancholia. Epilepsy, syphilis, alcoholism, and pellagra were also considered forms of insanity. The nineteenth century theory of reflexivity was the understanding by medical practitioners that the body influences the mind.[6]

I was interested in the gendered language of the classifications and supposed causes of mental illnesses that were attributed to admitted women at Dix Hospital. These supposed causes included "menopause," "uterine disease," "hysteria," "puerperal," "lactation," "childbearing," "pregnancy," and "menstrual irregularity." I wanted to better understand how the gendered language of supposed causes of female patients was connected to their supposed insanity while similar gendered distinctions and somatic connections were not made for male patients. 12.90% of female patients had a clearly gendered supposed cause. I was curious if there were similarities

[6] Edward Shorter, "Reflex Theory and the History of Internal Sensation" in *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Free Press), 40; an example from Dix Hospital is a woman having a supposed cause as "uterine disease" diagnosed with the form "melancholia."

in the manifestations or social identities of the 452 women with clearly gendered supposed causes.

I chose to focus on women who were described in the patient admission ledgers or general case book as suffering from "puerperal insanity" – disorders associated with pregnancy, childbirth, and lactation. I began looking for patterns, commonalities, and differences among these 159 patients reflected in the patient admission ledger and the 130 of who also had a record in the general case books. I started transcribing the general case book records and entering the data into a spreadsheet, following the same data structure as the CHW had used for the admission ledgers. I chose this Supposed Cause because it describes a distinct period in a woman's life and a physical, mental, and social change due to childbirth.

Housewives. Fear. Violence towards family members. Depressed. Excited. Trouble sleeping. Peculiar language and behavior. Even within the first ten puerperal patients I transcribed from the general case books, I began to see patterns and commonalities within the patients who were admitted with puerperal insanity. Their illness manifested in ideations, including a "fear of being killed" or a belief that "she has committed some unpardonable sin." There were also behavioral manifestations, including violence, threatening harm to others and herself, "foolish talking," and indifference to her home and family. The puerperal population shared commonalities in societal role, behaviors, and ideations.

Puerperal insanity is also interesting as it has a clear continuity in today's classification of mental illness. Supposed causes such as "uterine disease" or "menstrual irregularity" did not provide a clear causation that correlate to a contemporary mental illness as puerperal insanity does to postpartum psychosis and depression.

Puerperal Insanity

Lactation. Excessive childbearing. Pregnancy. Childbirth. These experiences were associated with the nineteenth century mental illness known as puerperal insanity.[7] Women whose mental illness was recorded to be triggered by the birth of the child or the time period following birth were categorized as having puerperal insanity. However, this mental illness was not seen as being caused only by the experience of childbirth. It was, however, understood during the nineteenth century as unlike the normal maternal role and relationship with her child.[8] Theriot writes, "the disease represented male physicians' definitions of proper womanly behavior. To nineteenth-century men, a woman who rejected her child, neglected her household duties, expressed no care for her personal appearance and frequently spoke in obscenities had to be 'insane.'"[9] The aversion to, fear of, or indifference to motherhood made this an illness that was distinct. Marland writes, "The description of the admission, diagnosis, therapeutic regimes and outcomes for [puerperal] patients build into a sad collection, with suicide attempts, self-harm, infanticide, terror, delusions and misery."[10] This mental illness had a clear connection to a distinct physical change for women in their bodies: childbirth.[11] The somatic connection between a woman's body and her mental illness was due in part to the theory of reflexivity during the nineteenth century; doctors at the time also thought external factors, including nutrition, environment, family, and other social strains, were involved in the onset of puerperal insanity.[12]

[7] Hilary Marland, "Disappointment and Desolation: Women, Doctors, and Interpretation of Puerperal Insanity in the 19th Century," *History of Psychiatry* 14:3 (2003): 303.
[8] Nancy Theriot, "Diagnosing Unnatural Motherhood: Nineteenth-century Physicians and 'Puerperal Insanity'." *American Studies* 30, no. 2 (October 1, 1989): 70.
[9] Theriot, "Diagnosing Unnatural Motherhood,", 74.
[10] Marland, "Disappointment and Desolation," 306.
[11] Marland, "Disappointment and Desolation," 307.
[12] Marland, "Disappointment and Desolation," 304.

Puerperal insanity was categorized by two forms, manic and melancholic. The manic form of puerperal insanity expressed itself in constant and sometimes obscene language, state of excitement, insomnia, refusal of food, "general meanness" towards others, homicidal attempts or aversion to family.[13] The manic form was diagnosed much more frequently in patients and occurred fairly soon after childbirth; manic puerperal insanity was considered fairly curable.[14] The melancholic form of puerperal insanity was expressed by a patient being "apathetic, hopeless and prone to suicide."[15] While this form of the mental illness was less frequently diagnosed, it sometimes led to dementia and perpetual admission to asylum.[16]

Literature Review

I am studying the female patients who were admitted to Dix Hospital for puerperal insanity because I wanted to find out how these admitted women's illnesses were understood and diagnosed in the cultural context of the time period. I also was curious if there were any patterns in characteristics and actions of the puerperal patients in the patient admission ledger and general case book. I want to help my readers understand the perception of puerperal insanity in the late nineteenth and early twentieth centuries in North Carolina.

I am using two sets of recently discovered primary source material: patient admission ledgers and general case books from the Dix Hospital Collection at the State Archives of North Carolina. I am examining these sources in the light of historical research in the interpretations of

[13] Theriot, "Diagnosing Unnatural Motherhood," 73.
[14] Marland, "Disappointment and Desolation," 308; Theriot, "Diagnosing Unnatural Motherhood," 73.
[15] Theriot, "Diagnosing Unnatural Motherhood," 73.
[16] Theriot, "Diagnosing Unnatural Motherhood," 73; Marland, "Disappointment and Desolation," 308.

puerperal insanity by asylum superintendents and other medical experts of the nineteenth and early twentieth century.

Hillary Marland's article "Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth Century" provides a foundational attempt to understand the triggers and contributing factors of puerperal insanity beyond pregnancy and childbirth. Marland's case study approach provided a structure for the first chapter and a collection of asylum records from Europe to compare to Dix Hospital patient records. In this way, the data can be compared to a similar population in order to situate the North Carolina hospital into a conversation with Marland's populations, recognizing variance and similarities and what each might mean in terms of the geographical space, temporal factors, and societal differences. Marland's work uses examples and statistics from asylum records and supplements these sources with physicians' interpretation of puerperal insanity in the nineteenth century.

Literature on female's experience with mental illness during the nineteenth century is used to contextualize the understanding of mental illness, especially gendered mental illness, during this time period. Nancy Theriot discusses the role of female reproductive organs in the explanation of mental illness and how that was affected by the lack of understanding of the female body as well as the lack of power women had in society. Theriot also discusses the normative and expected behavior of women during this time and the "medicalization and labeling of inappropriate behavior as disease."[17] Wendy Mitchinson discusses the medicalization of women's bodies and a culture that "pathologized some of the normal physiological processes

[17] Theriot, "Diagnosing Unnatural Motherhood," 71.

of women."[18] Mitchinson also describes how their medical conditions were recorded and rationalized.[19] Theriot and Mitchinson provide a foundational understanding of females as patients and the gendering of their diagnosis of mental illness in the nineteenth and twentieth centuries.

The concluding chapter of my thesis will focus on the current understanding of postpartum mental illnesses. Through studies conducted on the causation and likelihood of females having postpartum psychosis or depression, this chapter compares the current understanding to historical understanding of the puerperal population at Dix Hospital. Literature on the newly approved FDA drug Zulresso for postpartum depression will also be included, in discussion of the continued and current importance of the study and awareness of postpartum illnesses.

Chapter Breakdown

This thesis is divided into three body chapters. The first chapter uses Hilary Marland's case history research on the social factors and symptoms associated with puerperal insanity in the nineteenth century as a basis for comparison with the puerperal patients of Dix Hospital. Using statistical data from the transcribed patient admission ledgers and general case books, I compare the qualitative information of the North Carolina population to Marland's findings in order to distinguish variance and similarity. I also connect these qualitative findings to secondary

[18] Wendy Mitchinson, "Problematic Bodies and Agency: Women Patients in Canada, 1900-1950," *On the Case* (1998): 269.
[19] Mitchinson, "Problematic Bodies and Agency," 267.

literature that specifically discusses the role of femininity, maternity, sexuality, and domesticity in nineteenth century interpretations of women and madness.

My second and third body chapters are case studies of two of the women admitted for puerperal insanity at Dix Hospital. The use of primary source material, including census enumerations, marriage licenses, death certificates, gravestones, military records, and city directories provided a timeline and family tree for the patients. Social factors that affected the patient's life were gleaned from the primary source information including geographic location, their own or husband's occupation, and number of children. These two chapter narratives provide a structure of the patients' lives, but are in no way comprehensive of the social and familial factors that contributed to their mental illness. With the gaps of time where I could not locate the patient in public records, questions can only be asked but not answered.

The names in the second and third body chapters have been restricted to their first name and first letter of their given last name. I chose not to include the people's full names in order to preserve their anonymity.[20] After consulting articles for the ethics of public medical records, I decided to restrict the names in this way so they were not traceable in their initial form but could be traced to the sources I used in order to preserve the historic integrity of my research.[21]

My concluding paragraph discusses the longevity and legacy of puerperal insanity and today's medical understanding of perinatal illness. I will also discuss the importance of the FDA's recent approval of Zulresso, the first drug for the treatment of postpartum depression.

My thesis project is rooted both in the historical information of primary documents and secondary literature, as well as in the historiography. My focus on studying puerperal insanity is

[20] David Wright, "Madness in the Archives: Anonymity, Ethics, and Mental Health History Research," *Journal of the Canadian Historical Association* 23, no. 2 (2012): 71.
[21] David Wright, "Madness in the Archives," 71.

just one of many paths that can be taken with this rich primary source material from Dix Hospital. The choices I made on time period and who to include in my project are based on questions that intrigued me while transcribing the patient admission ledger with the Community Histories Workshop. In no way are the few cases I have selected comprehensive of the population of Dix Hospital. However, I would hope that future researchers can continue to question and grapple with the data to better understand even a small scale picture of mental illness in order to better empathize and de-stigmatize mental illness past and present.

Chapter 1: Statistical Understandings and Comparisons

"Puerperal insanity" was the term used by nineteenth century insane asylum superintendents to describe symptoms of insanity that coincides with pregnancy and childbirth. This chapter explores the nineteenth-century medical understanding of the causation and manifestations of puerperal insanity compared to the historical findings of Hilary Marland.

Hilary Marland, historical researcher of mental illness during the nineteenth century in her study of the history of medicine, wrote an analysis of her findings from asylum patient records in her article "Disappointment and Desolation: Women, Doctors and Interpretations of Puerperal Insanity in the Nineteenth Century." Marland provides an analysis of the case studies and supplemented her analysis with the understanding and interpretations of puerperal insanity of nineteenth century physicians. Through these source materials, Marland examines the physical symptoms, social factors, and behavioral manifestations that corresponded with the diagnosis of puerperal insanity. Marland writes, "Though the condition was seen as common to many women, case notes often provide detailed explanations of the onset of insanity, presenting the women as individuals with individual problems rather than a group of susceptible women with weak biological profiles."[22] Marland discusses multiple nineteenth century understandings of the contributing factors of puerperal insanity from a strictly biologically triggered illness to an illness with many relevant societal factors that impacted the health and diagnosis of the puerperal patients. She does so through research and analysis on the patient-based level with a case study focus.

[22] Marland, "Disappointment and Desolation," 306.

This chapter aims to situate the female patients diagnosed with puerperal insanity in Dix Hospital in relation to Marland's account.

Relevant Fields of Data in the Records

The admission materials available from Dix Hospital differ from those that Marland uses in her research. Marland's account is drawn from asylum registers and case books as well as more extensive case notes from private practices. She also uses the more detailed and extensive case histories of asylums' superintendents and assistants; these case histories often were recorded as longer narratives of individual patients' admission and treatment. Marland's records range from 1784-1865. The North Carolina records, as listed Table 1 and 2 in the Appendix, are two forms completed on the patient's intake. The patient admission ledger and general case books have structured fields in which the information was recorded; while there is room in the general case books for longer descriptions of treatment or patient histories, these longer narratives are infrequent compared to case histories Marland used for the basis of her account.

The materials from the State Archives of North Carolina include the patient admission ledger from 1856 - 1917 and the general case books from 1887 - 1918. These materials retain information that is unique to the patients at Dix Hospital that the materials Hillary Marland uses do not include or were not fields in the records. The patient admission ledger contains several fields that are relevant to the diagnosis and understanding of puerperal insanity, including age, occupation, social relation, number of attacks, supposed cause, duration before admittance, age of first attack, intake condition, length of stay, and final condition. The general case books shed even more light on the experience of puerperal insanity of patients, through the familial history, physical description, and supposed cause and qualitative manifestations. The family history

section lists other relatives who suffered from a mental illness. The physical descriptors provide insight on the health of the patient, including sleep, malnutrition, and physical state.

The general case book form includes information on the admitted person's relationship to their family. There are fields for both the patient's and the patient's mother's maiden name. There is a field for who brought the patient to the hospital. The name and address for a correspondent in the event of death is recorded, often the parent or spouse of the patient. This section of the general case books often gives us the full names of the spouse, father, and mother of the patient. Having three family members' names greatly aids in external genealogical research for case studies because it narrows the search and helps verify that it is the correct person in the record.

The family history section also includes information of hereditary conditions of insanity. This section includes medical information regarding the family, including their use and abuse of drugs and alcohol. This section is a means to see if there was a familial history of insanity. Sometimes it was indicated if there was a paternal or maternal history of mental illness, such as "Paternal uncle" listed as an Insane Relative. This family history section records insanity, substance abuse, physical deformities, and nervous condition. The records are a means for psychiatrists to find a hereditary predisposition to insanity for the admitted person.

The general case book also includes the physical condition and appearance of the patient on the day they were admitted. Fields for physical condition included: height, weight, muscular development, features, abnormalities and scars, general physical condition, and whether or not the patient was "filthy." Examples of General Psychical Condition included: "Thin, rather anemic," "Very feeble and emaciated," and "Well nourished." Abnormalities were most often

scars, bruises, or burns. From this recorded information, there is an idea of the toll the patient's mental illness had of their body.

The histories also provide in-depth descriptions of the "manifestations" of the patient's attack of mental illness–the symptomatic expressions of the supposed cause and form. The general case books accommodated three different manifestations. Manifestations could include ideations, such as delusions, hallucinations, and strongly held beliefs. These ideational manifestations included: "That witches are trying to kill her," "Imagines she is christ," "Imagines a conspiracy to kill or poison her," and "That she is a bad sinner." Themes of harm, fear, and religion recurred in these ideations. Behavioral manifestations were also recorded in the general case books. These actions included: "Tried to jump in well," "praying all the time," "Threatens to hurt others and burn everything," "Talking at random," and "Running up and down road, jumping and very noisy." Some manifestations were gender-specific; only women were listed as "talkative" in the field Peculiarities of Speech, for example. Other behaviors that were recorded included homicidal and suicidal threats or attempts. Characteristic manifestations are also included in the general case books, including whether or not the patient was depressed, excited, exalted, trustworthy, fearful, or coherent. These manifestations give insight into how the patients might have interacted with others and any breakage from the social norms.

The general case books provided a section for Remarks. Within this final field, notes on the patient's past triggering events are recorded for the cause of their initial admission. In some cases, treatment and reports on the patient's progress are recorded for subsequent months. The Remarks sometimes included a longer narrative of an experience the patient had that was presumed to have triggered their insanity. Detailed notes could include the number of children a patient had, other physical descriptions or aliments not included in their physical condition, and

other behavioral manifestations. While the rest of the general case book described the patient on the day of admission, the Remarks section gave more information to before admission and, in a few cases, life in the hospital.

The general case books' record of the family history, physical condition, manifestations, and remarks for each patient after 1887 provided a description of the patient on the exact day they were admitted to Dix Hospital. This unique document gives details and descriptions that the patient admission ledger did not have. The information in both primary source material from Dix Hospital combined with genealogical sources provides the opportunity for case studies.

The Dix Hospital materials contain more descriptive attributes rather than Marland's detailed narrative-based accounts. [23] A story of the North Carolina patients can be inferred from these recorded descriptions rather than more directly told as they are in Marland's research. Therefore, the information from the North Carolina patients add to the understanding through qualities of the patients rather than an individualized and personal narrative of their mental illness.

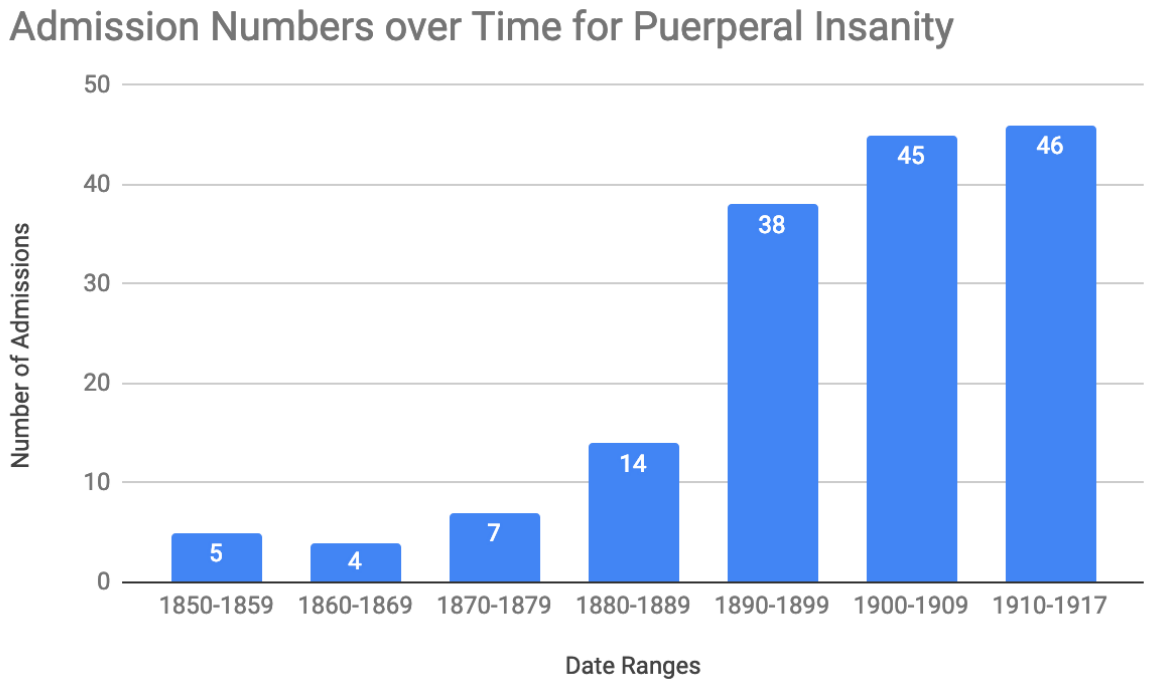
A piece that is very limited within Dix Hospital puerperal patient records is treatment of the mental illness once admitted; Marland discusses the treatment as "isolation from the family, rest and quiet, nutritious diet and tonics, gentle purging, calming medicines, encouraging patients to occupy themselves, and careful watching and nursing."[24] The puerperal patients at Dix Hospital have no indication of the treatment they received in the remarks section of the general case books, and, therefore, cannot be compared in this way to Marland's populations.

[23] Marland, "Disappointment and Desolation," 304.
[24] Marland, "Disappointment and Desolation," 316-317.

Population Breakdown

How common was asylum admission on the basis of puerperal insanity? Three thousand five hundred five women were admitted to Dix Hospital between 1856 and 1917. Of them, 159 (4.54%) are recorded as suffering from puerperal insanity or a related condition (lactation fever, pregnancy) in the "supposed causes," "intake condition," or "form" fields of the admission ledger. Nineteenth-century sources cited by Marland claim that between 10.00% and 12.50% of women admitted to British asylums presented with symptoms of puerperal insanity.[25]

Did the frequency of puerperal insanity diagnoses change over time? Marland's sources believed that the incidence of puerperal insanity in Britain increased over the nineteenth century.[26] This increase of diagnosis is consistent with the diagnoses at Dix Hospital, as seen in the graph below:



[25] Marland, "Disappointment and Desolation," 308.
[26] Marland, "Disappointment and Desolation," 304.

These figures do not reflect the occurrences of puerperal insanity in the general population in any country at this time, rather the relative frequency of diagnosis among women admitted for treatment at one asylum. Presumably the overwhelming majority of women who exhibited altered moods in the wake of childbirth in the nineteenth century did not report them to a doctor, and of those who did, only a small percentage would have been sent to an asylum. Therefore, these numbers indicate a population of women institutionalized rather than the total population of women experiencing puerperal insanity.

Were there different forms of puerperal insanity? Asylum doctors divided puerperal insanity cases into two types: maniac and melancholic. Puerperal mania was "attended with great excitement and furious delirium," including reports in the Dix Hospital as "running away, fighting, and using vulgar language" or "threatening to kill her children, rambling about at night."[27] Puerperal melancholy was "characterized by the features of low melancholy," including reports in the Dix Hospital as "weeping and sleeplessness" or "won't eat or do anything for herself." [28] Mania and melancholia were among the most commons "forms" of insanity in the nineteenth century, along with dementia and epilepsy. Marland's research reports that mania historically was recorded more frequently than melancholia, which remains true in the North Carolina hospital records.[29] In the Form field, 101 (64.33%) of puerperal patients were reported as having the manic form and 13 (8.28%) were melancholic.[30] While Marland does not describe the statistics of her research, she notes that doctors at the time were more concerned with the less

[27] Marland, "Disappointment and Desolation," 308.
[28] Marland, "Disappointment and Desolation," 308.
[29] Marland, "Disappointment and Desolation," 308.
[30] The other 28% of "forms" included forms such as "epilepsy," "dementia," and "imbecility."

frequently admitted melancholic puerperal patients due to its lasting impact of depression and its difficulty to cure this form.[31]

During the nineteenth century, motherhood was a woman's sacred duty. Women who denied or had an aversion to their maternal role were seen as "unnatural."[32] At Dix Hospital, women's denial of their maternity as visible through manifestations, including "neglect of duties and child," "no affection for baby," or "desire to kill herself, babe, and others." Women who suffered from puerperal insanity were treated "as if their female bodies were defective."[33]

The manic expression of puerperal insanity was called "flamboyant and associated with the contravention of all codes of decent female behaviour and maternal duty."[34] There are several fields in the general case book history that highlight these deviations from "decent female behaviour and maternal duty." 60 (46.15%) of the puerperal patients admitted to Dix Hospital were recorded as having a temper when admitted. 43 (33.08%) were recorded as using violent language, and 16 (12.31%) were recorded to be "talkative" in the Peculiarities of Speech field. Alongside this "unwomanly" verbal expression, there were also physical manifestations that violated the norms of "respectable" femininity. Forty nine (36.92%) of puerperal patients were reported to have irregular habits; 16 (12.31%) were reported as having evil or mischievous habits. 48 (36.92%) were marked as acting in a destructive manner. The women admitted with puerperal insanity broke social codes in their manifestations, denied their maternal roles, and spoke and acted indecently.

[31] Marland, "Disappointment and Desolation," 309.
[32] Theriot, "Diagnosing Unnatural Motherhood," 81.
[33] Nancy Theriot, "Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science," *Signs* 19, no. 1 (Autumn 1993): 21.
[34] Marland, "Disappointment and Desolation," 308.

Patient History

From the first admission ledger entries in 1856, it is clear that asylum doctors were troubled by the possibility that insanity was inheritable. The final section in the patient admission ledger, Remarks, sometimes pointed to relatives who were known or thought to be insane. One of the three notations under Intake Condition was "hereditary." General case book histories also reported mental illness in families in the fields Insane Ancestors and Insane Relatives. Did doctors regard puerperal insanity as more likely to occur among women who had "insane" family members? The puerperal cases that Marland studied reported "predisposition or hereditary explanations."[35] The Intake Condition field in the Dix Hospital admission ledgers contained "hereditary" for 18 patients (11.32%). The general case book histories delve more deeply into patterns of familial mental illness. Twenty nine (22.31%) of puerperal patients had entries for Insane Ancestors, and twenty five (19.23%) were noted as having Insane Relatives. The distinction between the categories of "ancestor" and "relative" is unclear; in some cases, it is generational (Insane Ancestors recorded as "two sisters, one brother" and Insane Relatives as "paternal grandmother and two uncles") but many of the fields contain "no" for both or contain the same information in both fields. These fields, as primarily either self-reported or reported by the person who brought the patient to the hospital, always were affected by the reporter's knowledge of the family history of mental illness. In this way, questions of the understanding and potential stigmas of mental illness during the late nineteenth and early twentieth centuries could have potentially swayed the patient's knowledge or wanting to report hereditary mental illness due to shame or lack of personal knowledge.

[35] Marland, "Disappointment and Desolation," 307.

What do we know about the social circumstances of the women admitted to any asylum for puerperal insanity? With regard to marital status, Marland reports that majority of those admitted with puerperal insanity were unmarried.[36] However, the asylums she studies for this marital factor differ from Dix Hospital in that they were hospitals that allowed bed rest for new mothers but discharged the women before symptoms appeared. Marland writes that apprehensions and anxieties linked to puerperal insanity impacted unmarried women more strongly; therefore, the high admittance of unmarried puerperal patients in Marland's research indicates how marital status might have affected the intensity of the manifestations of puerperal insanity and thus the higher rate of admission for the unmarried population. Dix Hospital had an overwhelming majority of 95.06% of the puerperal patients admitted that were married. This counters the idea that this was an illness that affected women due to the social stigma of mothering an illegitimate child.[37] The North Carolina records indicate that in the nineteenth and early twentieth century in North Carolina, married women were those primarily admitted to asylums for puerperal insanity.

Can we glean anything regarding the socio-economic status of women admitted for puerperal insanity? Marland discusses the impact of poverty and childcare that manifested in poor physical health of the patients in her case studies.[38] Malnutrition and poor physical health from breastfeeding was another attribute for the women admitted for puerperal insanity.[39] The general case books contain a number of fields reflecting socio-economic status and general physical condition of women admitted for puerperal insanity. One such field is Filthy. Roughly one quarter (31 cases, 23.85%) were so described, marked as yes to their "filthy" appearance.

[36] Marland, "Disappointment and Desolation," 312.
[37] Marland, "Disappointment and Desolation," 312.
[38] Marland, "Disappointment and Desolation," 311.
[39] Marland, "Disappointment and Desolation," 311.

The field Abnormalities, Scars or Wounds of Head, Face or Body, and how produced indicates 20 puerperal patients (15.38%) of having some abnormality in their appearance. These abnormalities included: scars, bruises, burns, paralyzation, scratches, deformities, sores, and swelling. Seven percent were described as "anemic." From the information in the general case book histories, there is not a strong majority for physical appearance showing the malnourishment and poverty the women Marland studies experienced.[40] Marland speaks to the malnutrition of the female patient when she writes, "[alienists] were quicker to link the condition to poverty and need, physical exhaustion, malnourishment."[41] So while there was speculation to this poor nutrition of these patients by Marland, this is not a key characteristic for the puerperal patients of Dix Hospital.

Personality and Defining Characteristics

Childbirth was a physical trauma for all women in the nineteenth century. Was the act of childbirth itself especially debilitating for women regarded as suffering from puerperal disorders? Marland describes a "weariness" that could be traced through the puerperal patients in the case histories from the Royal Edinburgh Asylum and the Warwick County Lunatic Asylum.[42] This weariness she described "went beyond the physical, and factors harder to pin down but so prevalent that it is hard to overlook."[43]

What evidence do we have of the emotional state of women who were admitted to asylums with the diagnosis of puerperal insanity? Marland's research describes that

[40] Marland, "Disappointment and Desolation," 311.
[41] Marland, "Disappointment and Desolation," 310.
[42] Marland, "Disappointment and Desolation," 307.
[43] Marland, "Disappointment and Desolation," 307.

"despondency and depression were intrinsic to the disorder."[44] Puerperal insanity is broken down into the two forms mania and melancholia, yet Marland describes that depression was present in both forms of puerperal insanity, with patients experiencing periods of gloom or sadness.[45] Dix Hospital records "depression and despondency" in both forms of puerperal insanity as 65 patients (50.00%) have the Depressed field marked. Only 8.28% of puerperal patients were admitted with the melancholic form, yet 50.00% of the total puerperal population exhibited depressive symptoms upon their admission. This contributes to Marland's "intrinsic" nature of despondency in puerperal insanity.

James Reid, a physician in London in 1858, stated: "more rapidly immediately after parturition, there is superadded an acknowledged state of great nervous excitability."[46] While there is no field of data within the general case book histories nor the patient admission ledgers that indicate this combined state of "nervous excitability," there are fields within the general case book histories for Temperament and Excited. In the temperament field, 64 puerperal patients (49.23%) were indicated as being nervous. In the excited field, 53 puerperal patients (40.77%) were indicated as being excited. Thirty-six (27.69%) of the puerperal patients were indicated as both nervous and excited. The piece that cannot be known from the general case book histories is when the onset of this state manifested for patients. The general case book histories record the onset of the mental illness in general but not specifically the state of nervousness or excitement, especially if it occurs almost immediately after childbirth as the London physician stated from Marland's research.

[44] Marland, "Disappointment and Desolation," 313.
[45] Marland, "Disappointment and Desolation," 313.
[46] Marland, "Disappointment and Desolation," 307-308.

Marland reports that the majority of the puerperal patients report "fright" as a manifestation in their illness, including that of pregnancy itself, their husbands, or abandonment.[47] For the patients of Dix Hospital, the general case book histories have a data field for Fear, and How Shown. Thirty (23.08%) of the puerperal patients reported that there was some type of fear that manifested. These fears included "fear of being killed or poisoned," "of witches," "of waking up in Hell," "of her husband," "of crowds," "of injury," "of people in general," and of "her own actions." While not a definite majority of patients citing fright, about a quarter of the puerperal population of the North Carolina hospital did record fear as a manifestation of their puerperal insanity.

Curability

Puerperal insanity was an illness that was deemed highly curable, most often within a few months.[48] Physicians were historically eager to treat patients with puerperal insanity because of its purported high success rate of 70% and shorter time of treatment compared to other afflictions.[49] The puerperal patients at Dix Hospital had a recorded cure rate of 52.83% (84 patients). Nineteen patients (11.95%) were recorded to have been improved in their final condition. The average length of stay for the patients with a Final Condition being "cured" or "improved" was 1 year, 4 months, and 21 days. This significantly longer length of time in the asylum calls into question the differences in treatment and condition of women upon intake as to how it affected their length of stay.

[47] Marland, "Disappointment and Desolation," 308, 314.
[48] Marland, "Disappointment and Desolation," 306.
[49] Marland, "Disappointment and Desolation," 306, 308.

Other Information

There are some unique fields in relation to the general case book histories and patient admission ledger that have notable trends in the puerperal patients of Dix Hospital that are not indicated in Marland's research. The patients' use of drugs prior to admission to the hospital is noted in the general case book histories in the field Use of Opium, Liquors, Tobacco. Sixty-four (49.23%) of the puerperal population have indicated in their histories that they use, alcohol, tobacco, or some combination of these drugs. Whether or not these drugs were used for a curative purpose for their mental affliction before admission or if they had an addiction to one of these drugs was not noted in these records. As the records do not include the treatment of the puerperal patients, whether or not additional drugs would have been given to patients is not known. However, the fact that just under half the puerperal population used one or more of these drugs before their admission for puerperal insanity is important to note because historically southern women were often prescribed opiates for their pains and thus had a high rate of addiction.[50]

Does there seem to be a relationship between puerperal disorders and suicidality? Another piece of information that was not indicated in the literature by Marland on puerperal patients is their tendency towards suicidality. The general case book records indicate that 39 puerperal patients (30.00%) indicated suicidal threats, and 19 puerperal patients (14.62%) indicated attempted suicide. Within the patient admission ledger, 39 (24.53%) of puerperal patients were indicated as being suicidal in their Intake Condition.

[50] David Courtwright, "Addiction to Opium and Morphine" in *Dark Paradise: A History of Opiate Addiction in America* (Cambridge: Harvard University Press, 2009), 41.

Do we have any indication of how aware puerperal insanity patients were of their supposed malady? This was, of course, a judgement of those in a position to make this determination. Fifty-nine patients (45.38%) were indicated as having "no" self-knowledge of their mental illness in the field Self-knowledge of Mental Condition. This information is important to note as a large portion of the puerperal patients were indicated as being unaware of their mental state; this brings to question whether or not they might have fought being admitted as they were unaware that they were sick at all. It brings to question whether others were deciding that the state of the patient had gotten to the point of a need for admission.

The puerperal population at Dix Hospital contribute to Marland's conversation of puerperal insanity's social factors and triggers. Due to the other asylums' international locations and slightly earlier time periods than Dix Hospital, there are differences in the understanding of puerperal insanity at the different times and places. The way Dix Hospital patients were described and treated for mental illness was most likely influenced by the social norms of the South. The time period and the medical understanding of puerperal insanity could affect the information that was taken on the time of admittance. Dix Hospital adds important descriptions of puerperal insanity that both augment and complicate Marland's account. The historical understanding of admission for puerperal insanity can expand through comparative studying of asylum records.

Chapter 2: Amelia B.

> *On October 24, 1892, Amelia B. traveled over 100 miles with the deputy sheriff of Wilmington to Dix Hospital. She was recorded as, "Patient is pale and thin, cries occasionally and seems deeply grieved over her child left at home. She has a baby 12 or 13 months old, and about 3 months after its birth symptoms of insanity became apparent, supposed to be due to "childbirth" and a severe attack of La Grippe. She threatened to kill herself and child. Her great desire is to go home, as she calls it, to her mother in heaven."*

Amelia B., while initially diagnosed for puerperal mania, was later admitted twice for melancholia. The melancholic form of puerperal insanity was seen less frequently in asylums, but this form of the illness concerned medical professionals during the nineteenth century for its residual impact on a patient's life, sometimes resulting in continued depression or dementia.[51] This chapter explores the impact of puerperal mania and melancholia on the life of Amelia B.

Family History

Amelia B. was born in January 1860 to William B.[52] and Julia S.[53] in New Hanover County, North Carolina. Julia S. married William B. sometime before the year of 1860. When Amelia B. was just two-years-old, her father at age 36 enlisted in the Confederate Army in

[51] Marland, "Disappointment and Desolation," 309.
[52] National Archives and Records Administration (NARA); Washington, D.C.; *Compiled Service Records of Confederate Soldiers Who Served in Organizations from the State of North Carolina*; Series Number: *M270*; Roll: *32*; William B. was born in Sampson County, North Carolina around 1826.
[53] 1870 United States Census, Magnolia Township, Duplin County, North Carolina: p. 23, family #161, dwelling #161, lines 17-23; August 24, 1870; Julia S. was born on June 11, 1841 in North Carolina.

Clinton, NC on May 16, 1862.[54]

With her husband off at war, Julia S. gave birth to a son William Robert B. on September 6, 1862 in Magnolia, NC in Duplin County.[55] Julia S. cared for her two young children, William Robert and Amelia, at home.

The role of Amelia B.'s biological father in her life is unknown. Because he enlisted when she was two-years old and there is no record of his return to the family, whether the two had any relationship at all is unknown. William B. deserted his regiment on May 25, 1863.[56] The circumstances of his desertion are not known. This record of his desertion is the last document of William B. found in public records. There is no record of his return to his family in Duplin County or his death. The desertion during the Civil War opens the possibility of his desertion of his family. However, there is no record of either William B. or Julia S. for a three-year period from the day in which he deserted to the day she remarried in 1866. It is unclear whether or not he was welcomed home and died soon after or left his family after his time fighting in the Confederate Army and never returned home. The presence of a father figure for Amelia from age 2 until age 6 is unknown and potentially nonexistent.

On June 24, 1866, Amelia B.'s mother, Julia S. married Isaac M.[57,58] The next time Amelia and her blended family appear in public record is seven years later in the 1870 census enumeration. Amelia B., recorded as "Ann M.," lived with her mother, younger brother, step-

---

[54] *Compiled Service Records of Confederate Soldiers*, NC, Series Number: *M270*; Roll: *32*; A six-foot-tall Private in Company C of the North Carolina 5th Cavalry Regiment 63 State Troops.
[55] Certificate of Death: Mr. William. B. Filed 09 September 1939. Commonwealth of Virginia, Dept. of Health Bureau of Vital Statistics, Reg. Dist. No. 19329, Reg. No. 1318. Informant: William Robert B., Norfolk, Virginia.
[56] *Compiled Service Records of Confederate Soldiers*, NC, Series Number: *M270*; Roll: *32*
[57] North Carolina, Marriage Records, 1741-2011. Isaac W. to Julia B., 24 June, 1866, Sampson County, North Carolina.
[58] Isaac M., North Carolina Troops 1861-1865, A Roster, U.S., Civil War Soldier Records and Profiles, 1861-1865, accessed through Ancestry.com 16 April 2019; Isaac M., who was born around 1834, was a farmer in Sampson County. He enlisted in the Confederate Army on April 20, 1861. During his time in the Confederate Army, Isaac M. was promoted three times; his final promotion to Full Private was awarded on November 1, 1863.

father, and three step-siblings in Magnolia, NC in Duplin County.[59] In 1870, the blended family of seven was living and working on the family owned farm. Amelia, age 10, was seven years older than her step-siblings; this is a significant age gap that could have affected the nature of the relationship between Amelia and her step-siblings.

Amelia is not seen in the public record for 10 years. At age 20, she is recorded in the 1880 census enumeration as living with her family in Wilmington, NC.[60] She is single and working as a cook.[61]

Amelia B., age 29, married Jacob C. in Wilmington, North Carolina on November 28, 1889. This is the first time Amelia appears in public records after nine years. Jacob C., age 46, was a widow with five children when he married Amelia B. Amelia, age 29, would have been considered very old to be just marrying for the first time. A woman entering her first marriage in her late twenties breaks the norm in the late nineteenth century in the South. What was the nature of her social relationships during the nine years Amelia is lost from public record from 1880-1889? Why was Amelia single until nearly 30 years of age? While these questions cannot be answered, it is necessary to note in the context of her role as a wife and a step-mother.

In 1892, Amelia B. experiences two major life changes. On May 3, 1892, Julia S., Amelia's mother, died in Richmond, VA. Five months afterwards Amelia gave birth to her child, Rufus C., on October 19, 1892. Having been married for over three years prior to the birth of her

[59] 1870 United States Census, Magnolia Township, Duplin County, North Carolina: p. 23, August 24, 1870; Julia S. and Isaac M. had three children, James M. (1867), Henry M. (June 4, 1868), and Dora M. (April 6, 1870), together by the time of the 1870 census enumeration.
[60] 1880 United States Census, Wilmington, New Hanover County, North Carolina: p. 31, family #336, dwelling #245, lines 6-14; June 9, 1880; the 1880 census enumeration recorded Julia S. and Isaac M. having had three more children: Anna M. (November 10, 1872), John M. (1876), and Oscar M. (1879).
[61] 1880 Census, Wilmington, North Carolina: p. 31; Amelia's last name was indicated as her biological father's last name in this census rather than assuming her step-father's last name as she did as a 10-year-old in the 1870 census; William Robert B., age 18, is living back in his birth town of Magnolia, NC working at a farm laborer at the time of the 1880 census enumeration.

son, it would be unusual for a housewife living on a farm to not have a child until three years into the marriage.

Personal History

On October 24, 1892, five days after the birth of Rufus C., Amelia B. was admitted to Dix Hospital for the first time.[62] Within the span of five days, Amelia B. went from a wife to a mother to a patient. At the age of 32, Amelia was older than the average female patient admitted for puerperal insanity at Dix Hospital.[63] The general case book history, as described in the introduction chapter, includes a description of the patient's physical appearance on the day they entered the hospital. This document gives readers a window into the individual's existence on a single day; the information recorded allows for an intimate understanding of the exact day the patient was admitted to Dix Hospital.

Amelia's physical health and appearance, although not previously recorded in other public record, was very poor on the day of her admission. The general case book indicates that Amelia's General Physical Condition was "thin and anaemic." She had a scar under her left eye and was noted as having "poor" muscular development. It was recorded that Amelia "complains of a pain throughout her body" in the section Any other Defects or Perversions of Feeling, Intellect or Will, or Abnormalities of any kind. Her thin appearance could be the result of her refusal to eat "at times" and having a "poor" appetite. Puerperal insanity historically was known as a "particularly visible and recognizable disorder … and the link with bodily health was

[62] Certificate of Death: Rufus C. Filed 21 August 1945. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 65-90, Reg. No. 387. Informant: Mrs. Anna W., Wilmington, North Carolina.
[63] The average age for puerperal insanity admission was 30-year-old.

deemed particularly important in the case of puerperal insanity."[64] Therefore, this poor physical state of Amelia B. could have been a visible symptom and factor for her admission. Despite having just given birth days before and her described poor diet, her urinary and sexual functions, including menstruation, are indicated as "probably regular." In regard to her temperament, Amelia was marked as "phlegmatic" in her Temperament and as "very nervous" in Paralysis or any other Nervous Disorder. It also states that she was "easily frightened."[65] From the described physical state of Amelia, no observations can be confirmed if she was experiencing a newly declining health or if she was a regularly thin female who was more cautious and wary of others. She easily could have been frightened because she was just taken from her newborn child and admitted as a patient at Dix Hospital.

Supposed Cause

Amelia's patient admission ledger records "puerperal" as her Supposed Cause; however, her general case book suggests that her Supposed Cause was complicated by her suffering from influenza, as it reports "Childbirth and La Grippe."[66] In Amelia's case, these two causes relate to a very immediate trigger from her birth of her son five days prior as well as her more prolonged suffering from influenza.

Amelia's timeline for the onset of her puerperal mania is complicated by the duration of her attack before admittance and the Remarks of her general case book. Both the patient

[64] Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*, (Basingstoke: Palgrave Macmillan, 2004), 103.
[65] Anne Digby, "Women's Biological Straitjacket," in *Sexuality and Subordination: Interdisciplinary Studies of Gender in the Nineteenth Century*, ed. Susan Mendus and Jane Rendall (New York: Routledge, 1989), 201; The understanding of early psychiatry was that pregnancy, childbirth, and the period after that there was an imbalance of "circulation" in which mothers could become more susceptible to fear and nervous instability.
[66] La Grippe was a term used for influenza at the time.

admission ledger and the general case book indicate that her mental illness started showing symptoms "about 10 months" prior to her admittance to Dix Hospital. Puerperal mania, however, usually occurs fairly quickly after childbirth.[67] The "puerperal" indicator did not initially seem out of place as Rufus C. was born only five days prior; however, the supposed onset of her mania ten months prior complicates the connection between the birth of Rufus C. and the onset of her puerperal mania. Her notes in the Remarks section of the general case book reported that she "seems deeply grieved over her child left at home. She has a baby 12 or 13 months old, and about 3 months after its birth symptoms of insanity became apparent." These remarks were most likely written on the day in which she entered the hospital; notes were sometimes added later in the patient's stay at the hospital updating their progress, but those notes were usually marked with the specific date of entry. Therefore, who was "her child left at home"? Between the marriage of Amelia and Jacob and the birth of Rufus, I have not found documentation of another child's birth in my research. Was Amelia's puerperal mania triggered by the birth of a child before Rufus? The remarks are written as though there was only a singular child in Wilmington, NC. The word choice "grieved" also surfaces the ideas of death and mourning; could there have been another child that had died after its birth twelve to thirteen months ago? As described earlier, Amelia had been married three years before having Rufus; the Remarks section results in the question of Amelia having given birth to another child before Rufus. However, if the baby was in fact born "12 or 13 months ago," there still would be no record of this child in the 1890 census enumeration, and thus not trackable before her admission.[68] These questions are only

[67] Marland, *Dangerous Motherhood*, 43; Puerperal insanity manifested usually within six weeks after childbirth.
[68] Marland, *Dangerous Motherhood*, 43; Debate on whether puerperal insanity manifested after subsequent births was debated among medical professionals during the nineteenth century. Some argued that it was primarily present with the birth of the first child while others linked the multiple attacks of puerperal insanity to the physical and mental taxation of pregnancy and childbirth.

answered with silence at this time. The notes that the general case book Remarks provide on October 24, 1892 are the only source that provides any indication of a second child that have been found. The Remarks of "the child left at home" complicates Amelia's history with childbirth, miscarriages, or stillbirths and the potential influence that these events could have had on her mental state.

Amelia B.'s puerperal insanity was reported to have manifested in her attempts to kill herself and her child.[69] Her illness was also flagged by her "despondency, peculiar conduct, and delusions." She was depressed and excited. Her notes give further hint of her mental illness:

> Patient is pale and thin, cries occasionally and seems deeply grieved over her child left at home. She has a baby 12 or 13 months old, and about 3 months after its birth symptoms of insanity became apparent, supposed to be due to "childbirth" and a severe attack of La Grippe. She threatened to kill herself and child. Her great desire is to go home, as she calls it, to her mother in heaven.

Her suicidality and grief are Amelia's depressive symptoms that give the impression of the sadness she was feeling at the time of her admission.[70] Her desire to die is also seen in her dream to be with her recently deceased mother "in heaven." These Remarks in the general case book describe the manifestation of the immense sorrow Amelia had experienced within the year of her admission, with the loss of her mother and the separation from her child.

---

[69] Marland, *Dangerous Motherhood*, 171; Marland writes: "Infanticide represented the antithesis of female nature, a total rejection of maternal ties, duties and feelings. Puerperal insanity could explain this, with the mother becoming, as a result of her mental disorder, confused, despondent or driven to a murderous fury."

[70] Marland, *Dangerous Motherhood*, 129; 24.53% of the puerperal population, as recorded in the patient admission ledger, was reported as "suicidal" in the intake condition. The general case book reports that 30.00% threatened suicide and 14.62% attempted suicide. Physicians in the nineteenth century believed that "women suffering puerperal insanity were considered dangerous even if, in most cases, this was only a temporary phenomenon." Females suffering from puerperal insanity were often deemed dangerous to their children, family, and themselves.

Amelia B. was discharged on August 1, 1893 as "cured."[71] Amelia B. spent 9 months and 7 days at Dix Hospital, compared to the average length of stay for puerperal patients at Dix Hospital of 1 year, 4 months, and 21 days. After almost a year at the asylum, 33-year-old Amelia B. returned to Wilmington, NC. Just three years after being home, her husband Jacob C. died at the age of 53 in Wilmington, NC on January 8, 1896.[72] After just being in the hospital suffering from depressive symptoms most likely aggravated by grief, Amelia faced another reason for mourning.

Amelia B. remained in Wilmington, NC as a widow, as found in the Wilmington directories in 1903 and 1905.[73] The directories do not list her occupation, so there is no way to know what she was doing after her husband's death. There is also no indication of the whereabouts of her son Rufus C., who would have been 11 or 13, respectively. After being widowed, it is unclear if Amelia was with her child or living alone after the death of her husband.

Within the years following her husband's death, Amelia experienced a social and physical decline. On December 1, 1906 at the age of 45, Amelia B. was admitted once again to Dix Hospital. With her husband and parents having died, her half-brother and closest living relative A. E. M. was her contact. Her son was 16 at the time. Her occupation was indicated as a "Domestic" while previously had been "Housekeeping." This most likely indicates that she had to take up work after her husband's death, as a domestic usually worked in others' homes while farm and house wives kept their own homes.

Amelia's family and personal history was left blank upon this admission. Upon this

[71] Marland, "Disappointment and Desolation," 306; 53.83% of puerperal patients at Dix Hospital were deemed "cured" as their final condition. Puerperal insanity was also seen as a "curable" mental illness, often after only a few months in hospital.
[72] Rufus C., Application for Gravestone for Jacob C., War Department, 11 August, 1930.
[73] Hill Directory Company. *Wilmington, North Carolina, City Directory, 1903*. Wilmington, NC: Hill Directory Company, 1903, p. 82; Hill Directory Company. *Wilmington, North Carolina, City Directory, 1905*. Wilmington, NC: Hill Directory Company, 1905, p. 84.

attack, she was recorded to be filthy and had no self-knowledge of her illness. Her melancholia manifested in insomnia and refusal to eat. There was no indication of threats of suicide and homicide, which were very central on her first admission in 1892 in her general case book for her 1906 admission. She was still depressed but no longer excited. Her history states that she had "poor" memory and "poor" coherence. At the age of 45, Amelia would have been closer at this admission to menopause. However, unlike her first admission that connected her insanity to her reproductive health, this second admittance was not linked to her menstrual health. Amelia was in a destitute state ten years after the death of her husband. The attack, however, was said to have only began four months prior to her admission. There was no elaboration on any event that could have triggered this melancholic attack. It is also unclear of Amelia's relationships during the period between her husband's death and her second admission. Did she have anyone to care for her? Did she have a relationship with her son? In the field Sources of Information, her committal papers and herself are listed. In this case, it is unclear if her mental decline into melancholia was only realized four months ago, but could have existed for a longer period of time. This manifestation four months ago could be due to a drastic change or an event in which her melancholia became apparent to her or others. With limited social interaction, Amelia's depression could have gone unnoticed or not impacting her life enough to seek help and hospitalization. She was discharged almost two years later as "cured" on November 23, 1908.

Amelia B. is not found in public record again until the 1910 census enumeration when she was living as one of five boarders, listed as "Roomer," in the home of Julia P. in Wilmington, NC.[74] While this appearance in public record confirms Amelia not living alone in 1910, her living in a boarding house opens the possibility for conflict with other boarders, as she

[74] 1910 United States Census, Wilmington Township, New Hanover County, North Carolina: p. 13B, family #174, dwelling #169, house #1572, lines 61-66; May 13, 1910.

was sharing a home rather than living on her own as she had been previously before her second hospitalization.

Amelia B., widowed and working as a "domestic" at the age of 51, was admitted for a third and final time to Dix Hospital on December 29, 1911. The general case book history reports that the deputy sheriff brought her to the hospital and her son was listed as her contact in Wilmington, NC.

There are multiple histories of mental illness in Amelia B.'s family. While the 1892 general case book history recorded that there was "probably" some insane relative in her family, the 1911 general case book records that there was "no" hereditary aspect to her mental illness. This is later refuted, however, by the fact that her brother William Robert B. was admitted to Dix Hospital sometime during or before 1930, as he is listed as an "inmate" at the hospital in the 1930 census enumeration at the age of 68.[75] Amelia B.'s stepchild James C. was also indicated to have committed suicide, dying of a self-inflicted gunshot wound on July 28, 1921.[76] While James C. did not have any direct hereditary relation to Amelia, his history of mental illness could affect Rufus C. as they shared the same father. While neither of these two male family members could have suffered from puerperal insanity, their mental illnesses suggest that there was a hereditary component to Amelia's mental illness.

Amelia B.'s physical appearance on admission was one of perceived good health. She was recorded as looking "well" in her general appearance in the general case book. At five feet and four inches, she weighed 132 pounds and had "good" muscular development. The field Filthy was left blank opposed to the affirmative answer she received in the same field on her

[75] 1930 United States Census, Raleigh City, Wake County, North Carolina: p. 11B, family #25, dwelling #23, line 82; April 9, 1930.
[76] Certificate of Death: James C. Filed 29 July 1921. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 652464, Reg. No. 345. Informant: A. J. F.

previous admission. She had a "good" appetite and no longer refused food or drink. Therefore, Amelia's physical condition on her third admission was not a symptomatic sign of her decline in her mental health as it had been in her two previous attacks.

It was in Amelia's behaviors that her mental illness manifested. Amelia posed no physical threat to anyone as she was recorded in the general case book not to be destructive or violent, although she did have a temper. Her memory had improved, but her coherence had not. After experiencing melancholia for "one year" before her admittance, what triggered this depressive state is unknown. Her manifestation of her melancholy is reported in the general case book in her "talk" and her "loss of memory for people." She also is said to "insists in wearing heavy clothing in summer." Amelia's behaviors and speech are perceived as strange and out of the ordinary. While she looked well, her mental illness manifested in her actions and her interactions. She had delusions of "thinks she has been cheated out of property by friends" and "unjustly treated at a boarding house." While these are written as delusions, they could have occurred in her living situation in Wilmington, NC. The last known residence of Amelia B. outside of the asylum was as a boarder in Wilmington, NC; potential mistreatment by other boarders to the 51-year-old widowed housekeeper would not be outside the realm of possibility; however, this potential ill treatment is documented as being imagined rather than being the truth.[77] The unusual circumstances of Amelia's living situation for her age and during this time period could have caused conflict at the boarding house. These delusions could have been rooted in her reality and potential turmoil she experienced in her living situation.

[77] Marland, *Dangerous Motherhood,* 125; Marland writes: "The delusions were often tenuously linked to the woman's social and family circumstances, her poverty, a traumatic recent confinement, shock or bad news, or ill treatment."

General Appearance and Remarks

Amelia's accessible information after 1918, including the final condition and length of stay in the patient admission ledger, is limited by the North Carolina Public Records Law. However, through census enumerations, marriage licenses, and death certificates, it is known that Amelia B. was an inmate at Dix Hospital from 1912 until her death in 1949.[78] These single snapshots of Amelia every decade in census enumerations silence understanding beyond her physical location and status as a patient for more than 30 years of her life. Did she interact with her brother or step-child during the overlap of their residence in the hospital? Did her depressive symptoms decrease? What was the treatment she received for her mental illness? It is known, however, that Amelia B. died in Dix Hospital on July 30, 1949 at 11:15 PM of Broncho Pneumonia, with Arteriosclerosis as a contributing cause.[79] The doctor who signed her death certificate acknowledged that he had attended to her since her third and final admittance to the hospital on December 29, 1911.

Amelia B.'s third and longest admission to Dix Hospital was for 37 years, 7 months and 1 day. Her total time in the hospital was 40 years, 3 months, and 30 days. Amelia B. died at the age of 89, spending almost half of her life as a patient at the Raleigh hospital. Her immediate family had all died before her, her son most recently dying on August 18, 1945. Her mental illness, triggered initially by the flu and childbirth, plagued the rest of her life.

[78] Certificate of Death: Amelia C. Filed 1 August 1949. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 92-90. Informant: State Hospital Records, Raleigh, North Carolina.
[79] Certificate of Death: Amelia C. Filed 1 August 1949.

Chapter 3: Bettie J.

Believing she had been poisoned and threatening her husband and friends, Bettie J. was admitted on August 30, 1909 to Dix Hospital. After a month of suffering from her attack of insanity, the sheriff led her in the doors and described her affliction to the medical personnel. She was expressionless and answered no questions, numb and unaware of her insanity in which she had just been admitted for.

Bettie J. was admitted for puerperal mania three months after the birth of her firstborn son. Puerperal mania was distinct from the melancholic form of puerperal insanity through its manifestations that broke societal "codes of decent female behaviour and maternal duty."[80] This chapter recounts the life of Bettie J. and her experience with mania and her subsequent attacks of mental illness throughout her life.

Family History

Bettie J. was born on February 15, 1889 to Thomas J.[81] and Missouri P.[82] in Northampton County, NC.[83]

On August 19, 1879, Missouri P. and Thomas J. were married in Northampton County, NC at the ages of 22 and 25, respectively.[84] The couple had five children together, and Bettie

[80] Marland, "Disappointment and Desolation," 308.
[81] North Carolina, Marriage Records, 1741-2011. Thos. J. to Missouri P., 19 August, 1879, Northampton County, North Carolina; Thomas J. was born in April of 1854 in North Carolina.
[82] Marriage Records, NC. Thos. J to Missouri P., 19 August 1879; Missouri P. was born around 1857 in North Carolina
[83] Find A Grave Index, Oak Ridge Cemetery, South Boston, Halifax County, VA, Betty J. P.
[84] Marriage Records, Thos. J. to Missouri P., 19 August, 1879.

was the youngest of the five.[85] There is no record of a divorce or death of Missouri P., but public records indicate that Thomas J. married another woman between 1890-1900.[86] The disappearance of Missouri P. from public record and the family questions the role and for how long Bettie J. had her biological mother in her life.

On March 14, 1900 Thomas J., age 45, married Nannie S., age 33, in Northampton County, NC according to their marriage license.[87] Three months later in the 1900 census enumeration, on June 20, 1900, Thomas J., was listed as married to Nannie S., in Wiccacanee, Northampton County, NC. The 1900 census enumeration reported that the couple had been married for ten years while their marriage registration recorded that they had only been married for the 3 months.[88] With Bettie J. born to Missouri P. just over a year before this census enumeration recorded her father remarried to Nannie S., Bettie's mother quickly falls out of the family picture. If the census enumeration is true, Thomas J. and Nannie S. were married in 1890, Bettie J. would have only been a year old when her father remarried; if this is so, Bettie would most likely not have any memory or established relationship with her biological mother. By the 1900 census enumeration, seven children were listed with the father of Thomas J. and mother of Nannie S.[89] Bettie J., age 11, would then be the youngest child of Missouri P. before her father's marriage to his second wife Nannie S. and birth of her two half-siblings.

[85] 1900 United States Census, North Wiccacanee, Northampton County, North Carolina: p. 15B, family #282, dwelling #275, lines 59-67; June 20, 1900.
[86] 1900 United States Census, North Wiccacanee, NC: p. 15B; Marriage Records, Thos. J. to Missouri P., 19 August, 1879, Northampton County, North Carolina.
[87] Marriage Records, Thos. J. to Missouri P., 19 August, 1879, Northampton County, North Carolina.
[88] 1900 United States Census, North Wiccacanee, NC: p. 15B
[89] 1900 United States Census, North Wiccacanee, NC: p. 15B; The seven children listed were: Herbert (age 18, born October 1881), Walter (age 16, April 1884), Lottie (age 15, April 1885), Clarah (age 13, February 1887), Bettie (age 11, February 1889), Edward (age 8, June 1891), Mattie (age 6, August 1893).

Bettie J.'s marriage documents complicate her identity. On March 18, 1906, Bettie J., age 17, married Charles P., age 27, in Northampton County, NC.[90] The Marriage Index listed that Charles P. was white, but it did not indicate the race of Bettie J. Their marriage license, however, records that Bettie J. was "colored."[91] Missouri P., Bettie J.'s biological mother, was not listed as colored in any of the census enumerations (1860, 1870, 1880) nor her marriage license, the documents that included a field for race. Her father, Thomas J., was also always indicated as "white" in his documentation in public record. This single documentation of Bettie J. as "colored" in the race field on her marriage registration is important to be noted in her biography but also important to note its singularity in its documentation.[92]

After three years of marriage, Bettie J., age 20, and Charles P., age 30, had their first son Thadeus P. on June 25, 1909 in Creeksville, NC.[93] During the early twentieth century in North Carolina, it is unusual for this to be Bettie J.'s first child. Therefore, this three-year gap surfaces questions of what Bettie was doing during this time period and if she had any unsuccessful pregnancies or childbirths before the birth of Thadeus. However, with the information available in public record, information of her past experience with pregnancies, miscarriages, or childbirth is unknown.

[90] North Carolina, Marriage Index, 1741-2004. Charles P. to Bettie J., 18 March 1906, Northampton County, North Carolina.
[91] North Carolina Marriage Index, Charles P. to Bettie J., 18 March 1906.
[92] None of the patients admitted for puerperal insanity in Dix Hospital were indicated of being a person of color.
[93] Social Security Applications and Claims Index, 1936-2007, Thad O. P., type of claim: duplicate request, claim date: 11 March 1974.

Personal History

Just three months after the birth of her son, Bettie J. was admitted to Dix Hospital on August 20, 1909. She arrived in a poor physical state. She was brought by the sheriff filthy and with a "feeble" appearance. Her "feeble" general appearance could have been affected by her refusal of food and drink. The general case book history also notes that she had "poor" muscular development and "expressionless" features. Bettie was "constipated" and had "poor" digestion. Her urinary and sexual functions were "irregular," and she had a "poor" appetite.

Her education and intellectual capacity were both reported as "limited."[94] She was a "housewife" and a wife of a "farmer." She had "irregular" habits and a "bilious" temperament. She was not reported to have used opium, liquor, or tobacco. This information from the general case book depicts a woman who was not educated and acted in a strange way. It is unclear if the peculiarities in her demeanor were newly onset or a personality characteristic of Bettie.

A family history of mental illness existed in Bettie's immediate family, her mother and brother were recorded as insane by the sheriff and her committal papers. Bettie's mother Missouri P. was not listed as a patient in Dix Hospital; however, the indication of her mother's insanity in Bettie's general case book as an insane relative does complicate her disappearance from public record after 1890. We do not know if Missouri P.'s insanity caused need for admittance or led to her death because records of her existence cease after 1889 with the birth of Bettie J. However, there is no found record of admission of Missouri P. as a patient after 1889 to Dix Hospital. She could have been admitted to another hospital, left the family and suffered alone, or died shortly after the birth of Bettie. Another possibility would be that the "mother"

[94] Marland, *Dangerous Motherhood,* 107; Women admitted with puerperal insanity, historically, had education that ranged from "modest" to "limited." Only two females admitted to Dix Hospital with puerperal insanity had a recorded "collegiate" education. The majority of this population had some education, ranging from "common school" to "limited."

listed was her step mother Nannie S.; as the information reported by the sheriff deputy rather than her Bettie herself, the distinction between biological and step mother might not have been made or known when Bettie was admitted.

Supposed Cause

Bettie J.'s illness manifested in aggressive and violent threats to herself and others; however, the general case book indicates that Bettie J. only engaged in self harm and did not enact violence to others.[95] Bettie J. was admitted with puerperal mania and her supposed cause was listed as childbirth. Her symptoms were reported to have begun one month prior to her admission, which would have been two months after the birth of Thadeus P. This two-month span between the birth of her child and the supposed onset of insanity denotes that either the symptoms were not apparent until that time or not to the extreme extent that would have caused the need for hospitalization. However, her general case book also noted that she had three previous attacks of insanity before her admission in 1909. Puerperal insanity was recognized as a recurring mental illness and a patient exhibited the most evident and severe symptoms soon after childbirth. While there is no found public record of Bettie J. having previous pregnancies before Thadeus P., the indication of three prior attack of insanity raises the question if Bettie had previously experienced symptoms of puerperal insanity despite this being her first admission.

Bettie J.'s illness manifested as threats: "threatens to fight husband and neighbors." She threatened to commit suicide and homicide; she had attempted suicide by the time of admission as well as committed assaults, as reported in her general case book.

[95] Theriot, "Diagnosing Unnatural Motherhood," 81; Violence was a common symptom of puerperal insane patients, a sign of them "not acting like women at all."

Her Intake Condition in the patient admission ledger reported that her mental illness was hereditary, suicidal, and puerperal, which were all three possible fields within the Intake Condition category.[96] Her suicidality was more of a symptomatic classification in this field, as seen in her behaviors and threats. The hereditary component showed that there was possibility for her insanity being an inherited illness and also relates to the general case book's indication of her mother and brother's insanity. The puerperal field showed that the mental illness had a direct link to the birth of Thadeus P.

At the time of her admission, Bettie J. approached interactions with hesitation and was distant to others and even herself. She was reported to be suspicious and distrustful of her friends. This suspicious state was augmented by her recorded delusions: "believes to have been poisoned."[97] Bettie was reported to have "no" self-knowledge of her mental illness nor any apparent coherence. She did not answer questions nor paid attention to her physical wants or her surroundings. Bettie was depressed and refused food and drink. She used violent language and had a temper.

The census enumeration for that decade was taken on May 11, 1910. Bettie still would have been a patient at the hospital at the time of the census enumeration, but she was listed as being at home in Wicancannee, Northampton County, NC with her husband Charles P., age 30, and Thadeus P., age 9 months.[98] The census enumeration indicated that the couple had been married for four years and had one child, Thadeus. Bettie J. would have still been a patient in Raleigh during the 1910 census enumeration as she was not discharged until November of that

[96] In the intake condition for the puerperal population at Dix Hospital, 18 (11.32%) were recorded as "hereditary," 91 (57.23%) as "puerperal," and 39 (24.53%) as suicidal.
[97] Marland, *Dangerous Motherhood,* 122-125; Marland describes that puerperal patients with delusions as "deeply distressed by these wrong beliefs." The reported delusions were also usually rooted in a woman's actual life circumstances.
[98] 1910 United States Census, North Wiccacanee Township, Northampton County, North Carolina: p. 22B, family #255, lines 70-72; May 11, 1910.

year. Appearing in the 1910 census enumeration in her hometown, Charles P. might have lied about Bettie's location in May 1910. His reasoning for this possible falsification could be motivated for several reasons, including shame linked to his wife's admission to the hospital or sadness because of his separation from her. However, it could have been that Bettie J. was in fact home on probation a few months before her official discharge from Dix Hospital on November 28, 1910. There was not a note in the Remarks on her general case book. Many patients who went home on probation had a record of this probation in the Remarks section, but this lack of notation in her general case book is not an absolute determinant of the possibility of her probation at the time of the census enumeration.[99]

After one year, three months, and eight days, Bettie J. was discharged as "cured" from the state hospital on November 28, 1910.[100] Less than a year later, Bettie J., age 22, gave birth to a daughter Elsie P. on August 25, 1911 in Conway, Northampton County, NC.[101] According to the patient admission ledger, Bettie J. was not admitted following the birth of Elsie as she had been after the birth of Thadeus. However, just because she was not admitted to the hospital does not erase the possibility that less severe symptoms of her puerperal mania could have resurfaced after the birth of Elsie P.

After the birth of Elsie there is no public record of Bettie J. for six years. The next public record found of Bettie J. is the birth of her daughter Esterbelle P. on April 25, 1917.[102]

Over a year after the birth of her third child, Esterbelle P., Bettie J. was admitted for a second time to Dix Hospital on May 1, 1918. She was brought by her husband Charles P., with

[99] Marland, "Disappointment and Desolation," 317; Marland writes: "Many asylums sent their patients out for a month's trial at home before finally discharging them." In this way, there was a sense of their functionality back in family life and the success of their treatment in hospital.
[100] At Dix Hospital, this length of stay was just shy of the average (1 year, 4 months, and 21 days) for puerperal patients.
[101] Birth Indexes, 1800-2000, Northampton County, North Carolina, volume 3, p. 675, Elsie P., August 25, 1911.
[102] Find A Grave Index, Oak Ridge Cemetery, South Boston, Halifax County, VA, Esther N.

instructions to inform him on event of her death. Her "brother and sister" were recorded to be insane relatives on her admission.

Bettie J. was admitted at 116 lbs. and 5 feet and 6 inches. She had "poor" muscular development. Her appetite was indicated as "not good," and she was recorded to use "Snuff." She was not recorded as filthy. So, while she was rather thin, Bettie J. was admitted in what seems to be a better physical health than her previous admission.

Bettie J. was admitted for dementia praecox, a term for what became known as schizophrenia.[103] However, the Supposed Cause was recorded as "unknown." Bettie J.'s manifestations were both behavioral and delusional. She "cries a great deal and tries to harm her Husband and children." Her behavioral manifestations also include threats and attempts at both suicide and homicide. She had a temper and was excited.

Bettie J. seemed to be grounded in reality on her admission, but still had some delusional manifestations. "Yes" was recorded regarding her ability to answer questions and her attention to her surroundings. Her sleep was "good," and she did not have peculiarities in her speech. However, she paid "no" attention to her physical wants. She also had illusions and hallucinations: "thinks her Husband is going to poison her." Bettie J.'s fear and distrust of her husband and her violence towards herself and others are the ideational and behavioral manifestations of her mental illness.

The length of stay for Bettie J.'s second admission is unknown. January 24, 1920, the date of the census enumeration, Bettie J. was still recorded as being an "inmate" at Dix Hospital.[104] It is unknown whether or not this was the same hospitalization since May 1, 1918 or

[103] In the Admission Ledger, the Form was listed as "D.P."
[104] 1920 United States Census, Raleigh Township, Wake County, North Carolina: p. 9B, State Hospital, line 70; January 24, 1920.

if she was discharged but quickly admitted again to the hospital sometime before January 24, 1920. This information of her discharge and final condition can be uncovered in the following years, as the North Carolina Public Records Law expands the availability of access to public records each year. Within the next few years, more in depth information on Bettie J.'s second admission will be accessible.

While the exact date of Bettie J.'s discharge is unknown, it is known that she was discharged before 1930, as she was living in South Boston, VA on April 2, 1930 according to the census enumeration.[105] Bettie J., age 38, was still married to Charles P., age 50.[106] Their daughter Esterbelle P. was 13-years-old and living with her parents.[107] The family of three lived in a rented home and earned their living through Charles P.'s work as a weaver at a cotton mill.

The question of which of Bettie J.'s "mother," her biological or stepmother, was insane, as indicated in the 1909 general case book, is complicated by her step mother's admission on August 3, 1922.[108] As there was no found record of her biological mother Missouri P.'s admission to an asylum or of her death, there is still a question to which "mother" was indicated when the sheriff brought Bettie to Raleigh in 1909. Nannie S. died on November 29, 1935 of Cardio-Renal causes.[109]

The next time Bettie J. surfaces in the public records was in the 1940 census enumeration.[110] She was 51-years-old and still recorded as being married.[111] However, she was

[105] 1930 United States Census, South Boston Township, Halifax County, Virginia: p. 1A, family #4, dwelling #4, lines 14-16; April 2, 1930.
[106] 1930 United States Census, South Boston Township, VA: p. 1A.
[107] 1930 United States Census, South Boston Township, VA: p. 1A.
[108] Certificate of Death: Nannie J. Filed 29 November 1935. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 92-90, Reg. No. 676. Informant: State Hospital Records, Raleigh, North Carolina.
[109] Certificate of Death: Nannie J. Filed 29 November 1935.
[110] 1940 United States Census, Staunton City, Augusta County, Virginia: p. 28A, Western State Hospital for the Insane, lines 17.
[111] 1940 United States Census, Staunton City, VA: p. 28A.

once again a patient at an asylum; in the 1940 census enumeration, the reported residence for Bettie J. was the "Sane House" in Staunton, VA.[112] At the time of Bettie J.'s admission, the Western State Hospital in Staunton, VA had a private unit in the hospital, the DeJarnette State Sanitorium.[113] This unit was named for Dr. Joseph DeJarnette, a psychiatrist known for his support of eugenics, especially the sterilization of the mentally ill.[114] DeJarnette also did experiments on his patients with a mental illness, including blood transfers between depressed and manic patients and x-ray exposure for sterilization.[115] He was superintendent at the Western State Hospital from 1906-1943.[116] He opened the DeJarnette State Sanitorium in 1932 for middle class patients who suffered from mental illness.[117] It not known if Bettie J. subjected to forced sterilization at DeJarnette State Sanitorium. From the denotation of "Sane House" it is difficult to confirm whether Bettie was admitted to the private sanitorium unit or the state hospital. Of the 8,300 patients in Virginia that were sterilized in the state, could Bettie have been one of them? Was puerperal insanity reason enough for DeJarnette to subject her to sterilization? With Bettie's patient records not available at this time, and her supposed cause for her admission before 1940 is unknown, could she have been admitted for another illness that was deemed reason for potential sterilization?

Despite Bettie J.'s multiple hospitalizations because of her insanity, her marriage did not end. On April 9, 1951 Charles P. died at the age of 72 after over 50 years of marriage[118]

---

[112] 1940 United States Census, Staunton City, VA: p. 28A.
[113] Trice, Calvin. "DeJarnette's Ugly, Complicated Legacy." The News Leader. August 31, 2017. Accessed April 01, 2019. https://www.newsleader.com/story/news/local/2014/03/22/dejarnettes-ugly-complicated-legacy/6753737/.
[114] "DeJarnette Sanitarium." Atlas Obscura. April 07, 2017. Accessed April 01, 2019. https://www.atlasobscura.com/places/dejarnette-sanitarium.
[115] "DeJarnette Sanitarium." Atlas Obscura.
[116] Trice, "DeJarnette's Ugly, Complicated Legacy."
[117] Trice, "DeJarnette's Ugly, Complicated Legacy."
[118] Find A Grave Index, Oak Ridge Cemetery, South Boston, Halifax County, VA, Betty J. P. and Charles P.; Bettie J. and Charles P. were buried together in Oak Ridge Cemetery in South Boston, VA.

However, it is not known if Bettie J. was with her husband at the time of his death or still a patient at the "Sane House."

General Appearance and Remarks

On June 20, 1957, Bettie J. died at the Western State Hospital in Staunton, VA of "chronic pyelonephritis," an infection of the kidney.[119] Her informant for her death was the State Hospital. She was a widow at the age of 68 when she died. It is not known the exact length of time she would have been a patient at the Western State Hospital as her date of her final admittance is unknown. Research is limited by the restrictions to access of the documents for Bettie J.'s admission information and length of stay.

Bettie J. has three known admittances to asylums during her lifetime. However, only the first admittance has a known supposed cause of attack. Two of her attacks followed her first and third child. The reason for her admission to the Western State Hospital is restricted at the moment from public access.

Bettie J.'s death was reported in the South Boston newspaper; she was survived by her three children and her siblings.[120] Despite her mental illness and her eventual death in the hospital, Bettie J. still had a familial support system. Her multiple admissions and her lack of an informant on her death certificate initially leave the feeling that she was alone in her illness. However, she was married to her husband for 50 years until his death and continued to have contact with her children and siblings as they wrote her a tribute in the local newspaper at the

[119] Certificate of Death: Bettie P. Filed 27 June 1957. Commonwealth of Virginia, Bureau of Vital Statistics, Reg. Dist. No. 2070, Reg. No. 300. Informant: Western State Hospital Records, Staunton, Virginia.
[120] "Mrs. Betty P. Services Saturday." *The Bee*, June 21, 1957, accessed April 01, 2019, https://universityofnorthcarolinaatchapelhill.newspapers.com/image/46816138/?terms=%22pulley%22.

time of her death. While the illness was most likely isolating in its symptoms, its treatment, and the time spent in hospitals, Bettie J. maintained a familiar support system through her lifelong suffering from mental illness.

Conclusion

On March 19, 2019 the first drug for postpartum depression, Zulresso, was approved by the Food and Drug Administration.[121] Zulresso is administered by IV drip to the patient for 60 continuous hours.[122] This drug works within days and can get new mothers back on their feet without the extreme symptoms of postpartum depression.

While this drug has been FDA approved, perinatal mental illnesses continue to be researched and studied by doctors to understand its causes and how to treat patients. Dr. Mary Kimmel, Medical Director of the UNC's Perinatal Psychiatry Inpatient Unit (PPIU) is a leading researcher on the causes and treatment for postpartum depression and psychosis. I was introduced to Dr. Kimmel at the AMST 840: "Digital Humanities/Digital American Studies" case study presentation on puerperal insanity. I later met with Dr. Kimmel on my own and shared more of the two cases I had researched. Dr. Kimmel wrote in an email:

> As the medical director of UNC's Perinatal Psychiatry Inpatient Unit, the first of its kind in the US, I was interested how the stories and cases found to date mirror current women's stories. There is much to learn about not only the history of disorders such as postpartum depression and postpartum psychosis, but also help us understand how we got to our current state of mental health, and answer questions about society's impact on mental health treatment. By looking over time who and due to what circumstances individuals have been diagnosed helps us continue to improve our definitions of disorders and our understanding of the many factors that impact and make up our mental health.

[121] "FDA Approves First Treatment for Post-partum Depression," FDA News Release, last modified 20 March 2019, accessed 5 April 2019, https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm633919.htm
[122] "FDA Approves First Treatment for Post-partum Depression," FDA News Release, last modified 20 March 2019.

This creates collaborations and information that can be used to improve our practice, to answer important questions for research and for teaching.

Puerperal insanity, or postpartum psychosis and depression, continues to be studied by doctors in order to provide the best care for their patients.

The causation and the perinatal period's connection to episodes of depression or psychosis continue to be studied. Whether it was an episode triggered by the birth of child or if the episode coincidently aligned with this event is unclear. Dr. Kimmel discussed that postpartum mental illnesses are still thought of as more curable in comparison to others illnesses. She also discusses that a hereditary component of mental illness is often seen in her diagnosed patients.

Kimmel continues to research the cultural and social factors of perinatal illness. She stated in my interview with her that a high percentage of patients she sees are married or have a partner in their life. She still questions, however, is this the population that seeks care? Are there more sufferers that do not receive medical attention because they have no one to bring them into hospital? She also wonders if there is a social stigma that might keep their families from seeking medical care. Are there cultural aspects, including religion and expectations of a women as a mother that filter the population of patients that she sees?

Dr. Kimmel continues to study the concept of delusions. She believes that most are heavily weighted in reality, but the beliefs are heightened or distorted. She also has patients who feel that their partners are gaslighting them, manipulating them in attempts to make them believe that they are insane.

Dr. Kimmel also discussed that attempted suicide is the number one reason for admission for her patients. Intrusive suicidal thoughts are reported for the majority of her patients, but the

extent of these thoughts varied among them. Dr. Kimmel described them often falling into one of two categories: egosyntonic and egodystonic. Egosyntonic thoughts are those in which the patient feels a need to commit the act of suicide or infanticide in order to save or help their child or out of fear of being harmed. Egodystonic thoughts were those that were not in line with what the patient wanted to do and horrifies them, but still has this intrusive suicidal or infanticidal thoughts.

The symptoms and characteristics recorded in the patient log at UNC's Perinatal Psychiatry Inpatient Unit align with those recorded in the intake materials from Dix Hospital. Both nineteenth and twenty first century mental illnesses that surround childbirth look not just at the physical change of a female's body but also the social influencers. Cultural surroundings and social relations are sought out in order to understand the illnesses, then and now.

Future Research

To get the most comprehensive understanding of the nineteenth and early twentieth century puerperal population at Dix Hospital, more case studies could be done. My future goal for this project would be to conduct more case studies. More information on the lives of patients outside of asylum would shed light on social factors beyond the ones recorded in the intake materials. The continued study of mental illness, past and present through the ideas of femininity, maternity, and insanity remains of pertinent and current importance in medical understanding of perinatal illnesses. I hope that my research aids and continues to illustrate these women as people rather than just patients, as natural rather than unnatural mothers.

Appendix.

Table 1. Patient Admission Ledger

Name
Occupation
Admission Date
Sex
Age
Social Relation (Single, Married, Widowed)
Number of Attacks
Supposed Cause
Duration before Admission
Age at First Attack
Suicidal
Puerperal
Hereditary
Nativity
Residence
Number of Admission
Discharge, or Death
Length of Residence in the Hospital
Final Condition (Cured, Much Improved, Improved, Unimproved, Removed, Eloped, Died)
Remarks

Table 2. General Case Book

	Registration Number
	Former Registration Number
	Number for Year
	Name
	Residence
	Admitted
	Age
	Sex
	Nativity
	Civil Condition
	Maiden Name
	Religion
	Education
	Occupation
	Intellectual Capacity in Health
	Habits
	Use of Opium, Liquors, Tobacco
	Temperament
	Correspondents Name and Address
	Brought by
	Instructions in Event of Death
Family History	Father’s Occupation
	Husband’s Occupation
	Mother’s Maiden Name
	Consanguinity of Parents and Grandparents

	Insane Ancestors
	Insane Relatives
	Deaf-Mutism of Ancestors or Relatives
	Epilepsy of same
	Drunkenness of addiction to use of Opium or Whiskey in same
	Paralysis or other Nervous Disorders of same
	Physical Diseases or Diatheses prevalent in same
	Physical Deformities or other Abnormalities in Ancestors or Relatives
Personal History	Weight
	Height
	Muscular Development
	Features
	Abnormalities, Scars, or Wounds of Head, Face, or Body, and how produced
	General Physical Condition on Admission
	Inherited, Constitutional, or Chronic Disease or Cachexia
	Sub-Acute or Acute Disease
	Appetite
	Bowels and Digestion
	Urinary and Sexual Functions (Menstruation &c.)
	Symptoms not ascribed to any Special Disease
	Epilepsy
	Chorea
	Paralysis or any other Nervous Disorder
	Previous Attacks of Insanity
	Date and Duration of same
	Former Admission into this or other Institutions, Date and Duration of Treatment

Duration of Present Attack	
Supposed Cause	
	First Manifestations
	Subsequent Manifestations
	Delusions and Character of same
	Illusions and Hallucinations
	Threats of Homicide
	Attempted Homicide
	Threats of Suicide
	Attempted Suicide
	Assaults
	Destructiveness or other Violent Acts
	Violent Language
	Temper
	Memory for Recent Events
	For Remote Events
	Depressed
	Excited
	Exalted
	Apparent Consciousness
	Self-knowledge of Mental Condition
	Trustworthiness
	Identity
	Filthy
	Attention to Physical Wants
	Attention to Surrounding

	Fear, and how shown
	Refusal of Food or Drink
	Sexual Propensities and Habits
	Evil or Mischievous Habits
	Answers Questions
	Coherence
	Sleep
	Peculiarities of Speech
	Suspicion and Distrust of Friends and Others
	Any other Defects or Perversions of Feelings, Intellect, or Will, or Abnormalities of any kind
	Diagnosis
	Sources of Information
	General Appearance and Remarks

Image 1. Patient Admission Ledger –Page 1

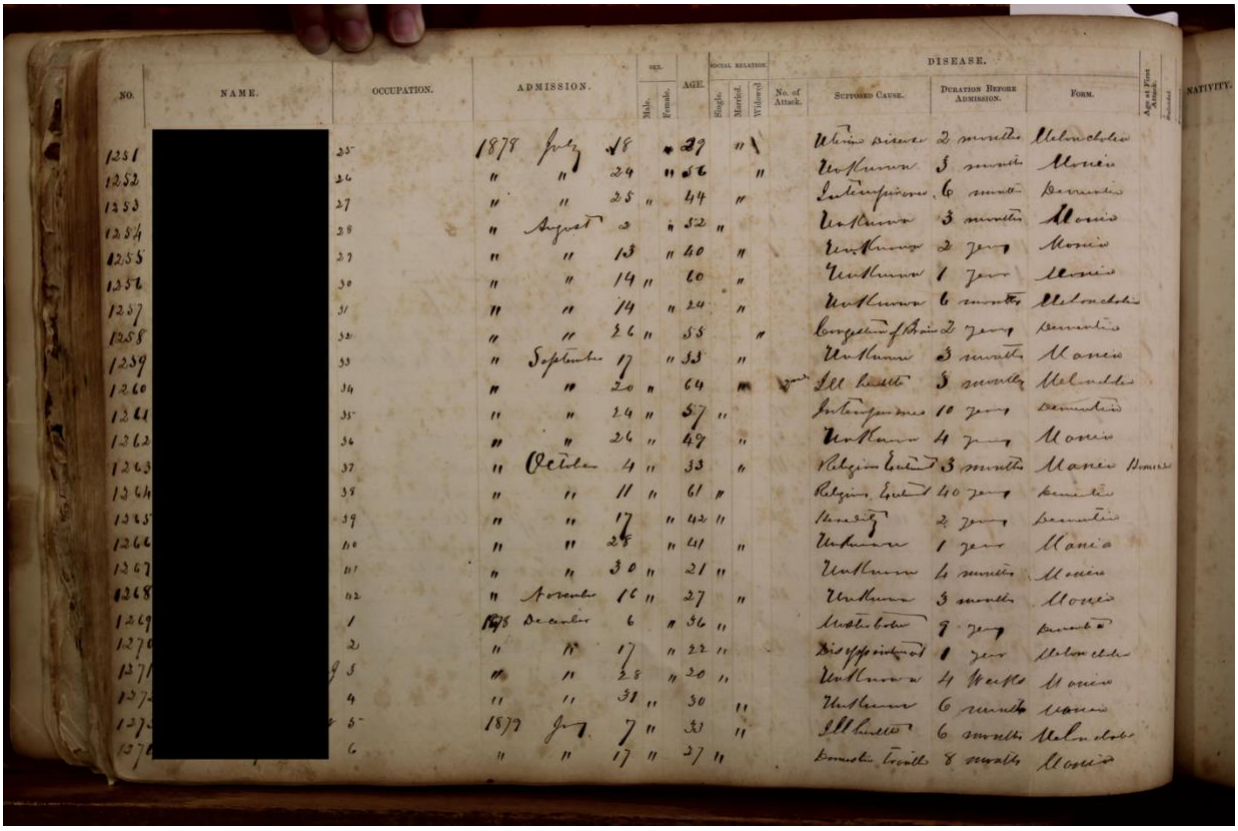
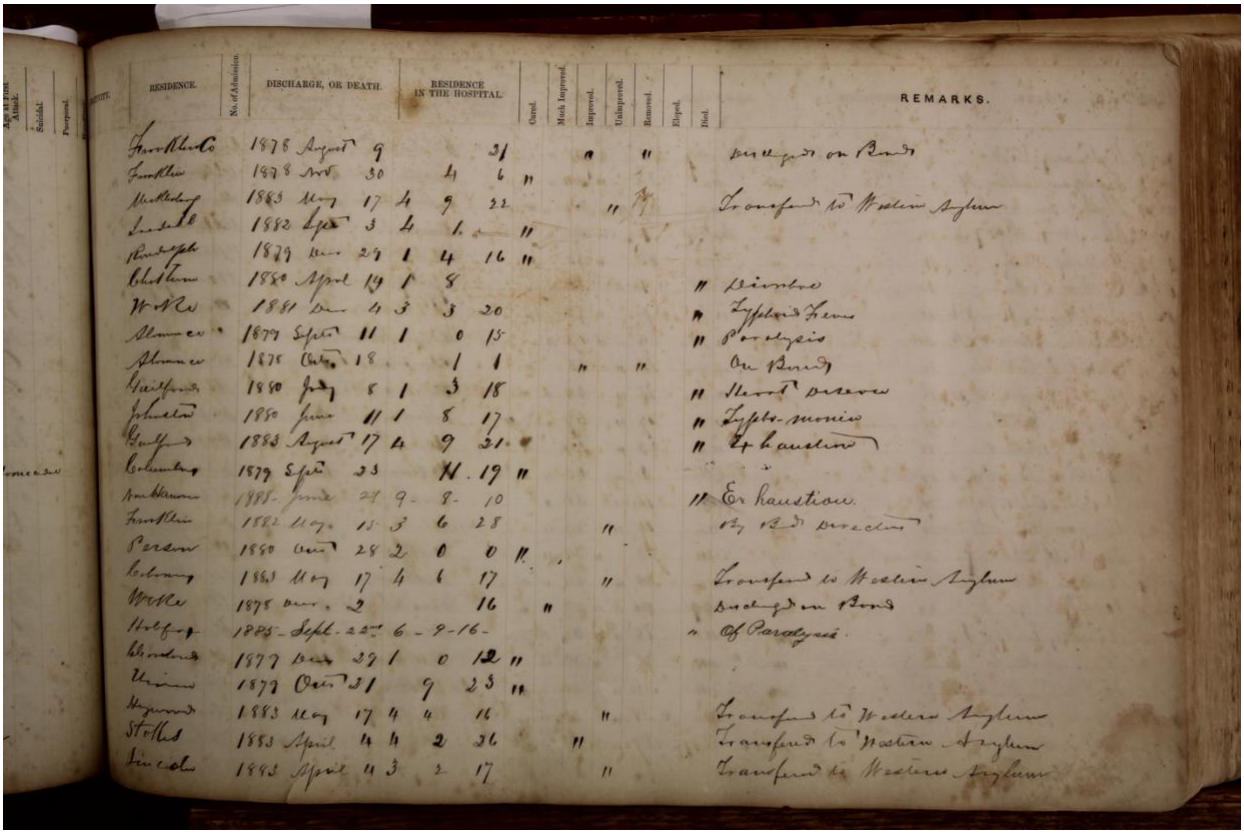
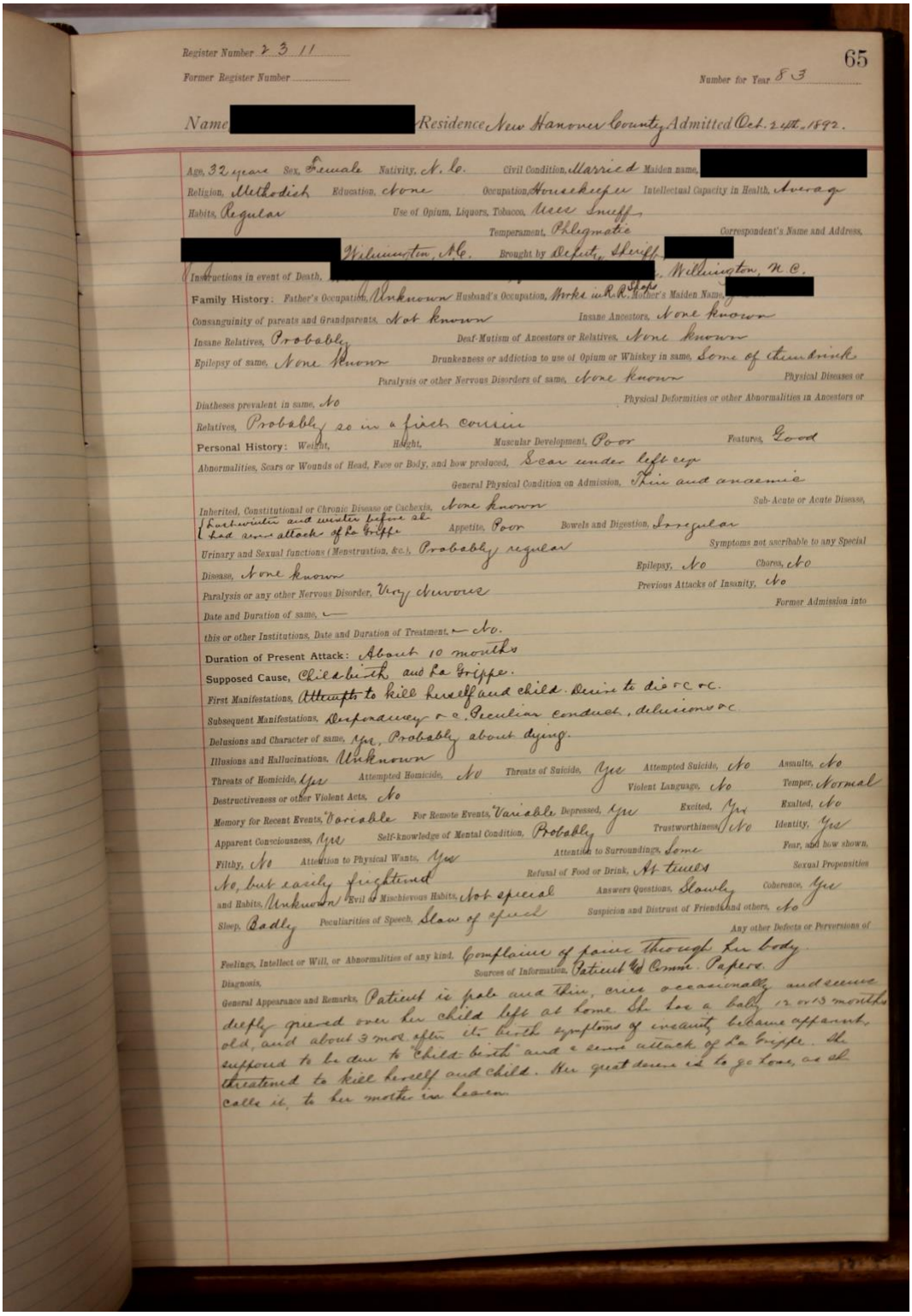


Image 2. Patient Admission Ledger – Page 2



RESIDENCE.	No. of Admission.	DISCHARGE, OR DEATH.	RESIDENCE IN THE HOSPITAL.	Cured.	Much Improved.	Improved.	Unimproved.	Removed.	Elopd.	Died.	REMARKS.
Smithfield Co		1878 August 9	3½			"	"				discharged on Bond
Smithfield		1878 Nov 30	4 6	"							
Middlebury		1883 May 17	4 9 22				"				Transferred to Western Asylum
Sandwich		1882 Sept 3	4 1.	"							
Randolph		1879 Dec 29	1 4 16	"							
Chittenden		1880 April 19	1 8							"	Died
Windsor		1881 Dec 4	3 3 20							"	Typhoid Fever
Glover		1879 Sept 11	1 0 15							"	Paralysis
Glover		1878 Oct 18	1 1			"		"			On Bond
Guilford		1880 July 8	1 3 18							"	Heart disease
Johnson		1880 June 11	1 8 17							"	Typho-mania
Guilford		1883 August 17	4 9 21.							"	Exhaustion
Columbia		1879 Sept 23	N. 19	"							
Brattleboro		1885- June 24	9- 8- 10							"	Exhaustion.
Smithfield		1882 May 15	3 6 28				"				By Bail process
Corinth		1880 Oct 28	2 0 0	"							
Corinth		1883 May 17	4 6 17				"				Transferred to Western Asylum
Middle		1878 Dec 2	16		"						discharged on Bond
Halifax		1885- Sept 25th	6 - 9-16-							"	Of Paralysis.
Brandon		1877 Dec 29	1 0 12	"							
Union		1879 Oct 31	9 2 3	"							
Hayward		1883 May 17	4 4 16				"				Transferred to Western Asylum
Stockbridge		1883 April 4	4 2 26			"					Transferred to Western Asylum
Lincoln		1883 April 4	3 2 17				"				Transferred to Western Asylum

Image 3. General Case Book



Register Number 2 3 11 — 65

Former Register Number ..... — Number for Year 8 3

Name [redacted] Residence New Hanover County, Admitted Oct. 24th, 1892.

Age, 32 years Sex, Female Nativity, N. Ca. Civil Condition, Married Maiden name, [redacted]

Religion, Methodist Education, None Occupation, Housekeeper Intellectual Capacity in Health, Average

Habits, Regular Use of Opium, Liquors, Tobacco, Uses Snuff.

Temperament, Phlegmatic Correspondent's Name and Address,

[redacted] Wilmington, N.C. Brought by Deputy Sheriff [redacted]

Instructions in event of Death, [redacted] Wilmington, N.C.

Family History: Father's Occupation, Unknown Husband's Occupation, Works in R.R. Shop Mother's Maiden Name, [redacted]

Consanguinity of parents and Grandparents, Not known Insane Ancestors, None known

Insane Relatives, Probably Deaf-Mutism of Ancestors or Relatives, None Known

Epilepsy of same, None Known Drunkenness or addiction to use of Opium or Whiskey in same, Some of them drink

Paralysis or other Nervous Disorders of same, None Known Physical Diseases or

Diatheses prevalent in same, No Physical Deformities or other Abnormalities in Ancestors or

Relatives, Probably so in a first cousin

Personal History: Weight, Height, Muscular Development, Poor Features, Good

Abnormalities, Scars or Wounds of Head, Face or Body, and how produced, Scar under left eye

General Physical Condition on Admission, Thin and anaemic

Inherited, Constitutional or Chronic Disease or Cachexia, None known Sub-Acute or Acute Disease,

Last winter and winter before at Appetite, Poor Bowels and Digestion, Irregular

had one attack of La Grippe

Urinary and Sexual functions (Menstruation, &c.), Probably regular Symptoms not ascribable to any Special

Disease, None known Epilepsy, No Chorea, No

Paralysis or any other Nervous Disorder, Very nervous Previous Attacks of Insanity, No

Date and Duration of same, — Former Admission into

this or other Institutions, Date and Duration of Treatment, — No.

Duration of Present Attack: About 10 months

Supposed Cause, Childbirth and La Grippe.

First Manifestations, Attempts to kill herself and child. Desire to die &c &c.

Subsequent Manifestations, Restlessness &c. Peculiar conduct, delusions &c

Delusions and Character of same, Yes, Probably about dying.

Illusions and Hallucinations, Unknown

Threats of Homicide, Yes Attempted Homicide, No Threats of Suicide, Yes Attempted Suicide, No Assaults, No

Violent Language, No Temper, Normal

Destructiveness or other Violent Acts, No

Memory for Recent Events, Variable For Remote Events, Variable Depressed, Yes Excited, Yes Exalted, No

Apparent Consciousness, Yes Self-knowledge of Mental Condition, Probably Trustworthiness, No Identity, Yes

Filthy, No Attention to Physical Wants, Yes Attention to Surroundings, Some Fear, and how shown,

No, but easily frightened

and Habits, Unknown Evil or Mischievous Habits, Not special Refusal of Food or Drink, At times Sexual Propensities

Answers Questions, Slowly Coherence, Yes

Sleep, Badly Peculiarities of Speech, Slow of speech Suspicion and Distrust of Friends and others, No

Any other Defects or Perversions of

Feelings, Intellect or Will, or Abnormalities of any kind, Complains of pains through her body

Sources of Information, Patient & Comm. Papers.

Diagnosis,

General Appearance and Remarks, Patient is pale and thin, cries occasionally and seems deeply grieved over her child left at home. She has a baby 12 or 13 months old, and about 3 mos. after its birth symptoms of insanity became apparent, supposed to be due to "Child birth" and a recent attack of La Grippe. She threatened to kill herself and child. Her great desire is to go home, as she calls it, to her mother in heaven.

Bibliography

1870 United States Census, Magnolia Township, Duplin County, North Carolina: p. 23; August 24, 1870.

1880 United States Census, Wilmington, New Hanover County, North Carolina: p. 31; June 9, 1880.

1900 United States Census, North Wiccacanee, Northampton County, North Carolina: p. 15B; June 20, 1900.

1910 United States Census, North Wiccacanee Township, Northampton County, North Carolina: p. 22B; May 11, 1910.

1910 United States Census, Wilmington Township, New Hanover County, North Carolina: p. 13B; May 13, 1910.

1920 United States Census, Raleigh Township, Wake County, North Carolina: p. 9B; January 24, 1920.

1930 United States Census, Raleigh City, Wake County, North Carolina: p. 11B; April 9, 1930.

1930 United States Census, South Boston Township, Halifax County, Virginia: p. 1A; April 2, 1930.

1940 United States Census, Staunton City, Augusta County, Virginia: p. 28A.

"About Us," Community Histories Workshop, accessed April 16, 2019, https://communityhistories.org/about/

Birth Indexes, 1800-2000, Northampton County, North Carolina, volume 3, p. 675, Elsie P., August 25, 1911.

Certificate of Death: Amelia C. Filed 1 August 1949. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 92-90. Informant: State Hospital Records, Raleigh, North Carolina.

Certificate of Death: Bettie P. Filed 27 June 1957. Commonwealth of Virginia, Bureau of Vital Statistics, Reg. Dist. No. 2070, Reg. No. 300. Informant: Western State Hospital Records, Staunton, Virginia.

Certificate of Death: James C. Filed 29 July 1921. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 652464, Reg. No. 345. Informant: A. J. F.

Certificate of Death: Mr. William. B. Filed 09 September 1939. Commonwealth of Virginia, Dept. of Health Bureau of Vital Statistics, Reg. Dist. No. 19329, Reg. No. 1318. Informant: William Robert B., Norfolk, Virginia.

Certificate of Death: Nannie J. Filed 29 November 1935. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 92-90, Reg. No. 676. Informant: State Hospital Records, Raleigh, North Carolina.

Certificate of Death: Rufus C. Filed 21 August 1945. North Carolina State Board of Health, Bureau of Vital Statistics, Reg. Dist. No. 65-90, Reg. No. 387. Informant: Mrs. Anna W., Wilmington, North Carolina.

Courtwright, David. "Addiction to Opium and Morphine" in *Dark Paradise: A History of Opiate Addiction in America* (Cambridge: Harvard University Press, 2009).

"DeJarnette Sanitarium." Atlas Obscura. April 07, 2017. Accessed April 01, 2019. https://www.atlasobscura.com/places/dejarnette-sanitarium.

Digby, Anne. “Women’s Biological Straitjacket,” in *Sexuality and Subordination: Interdisciplinary Studi*es *of Gender in the Nineteenth Century*, ed. Susan Mendus and Jane Rendall (New York: Routledge, 1989), 201.

“FDA Approves First Treatment for Post-partum Depression,” FDA News Release, last modified 20 March 2019, accessed 5 April 2019, https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm633919.htm

Find A Grave Index, Oak Ridge Cemetery, South Boston, Halifax County, VA, Esther N.

Find A Grave Index, Oak Ridge Cemetery, South Boston, Halifax County, VA, Betty J. P. and Charles P.

Hill Directory Company. *Wilmington, North Carolina, City Directory, 1903*. Wilmington, NC: Hill Directory Company, 1903, p. 82; Hill Directory Company. *Wilmington, North Carolina, City Directory, 1905*. Wilmington, NC: Hill Directory Company, 1905, p. 84.

Isaac M., North Carolina Troops 1861-1865, A Roster, U.S., Civil War Soldier Records and Profiles, 1861-1865, accessed through Ancestry.com 16 April 2019.

Marland, Hilary. *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*, (Basingstoke: Palgrave Macmillan, 2004).

Marland, Hilary. “Disappointment and Desolation: Women, Doctors, and Interpretation of Puerperal Insanity in the 19th Century,” *History of Psychiatry* 14:3 (2003).

McKown, Harry. "Dorothea Dix Hospital," NCpedia, last modified 2006. Accessed April 02, 2019, https://www.ncpedia.org/dorothea-dix-hospital.

Mitchinson, Wendy. "Problematic Bodies and Agency: Women Patients in Canada, 1900-1950," *On the Case* (1998).

"Mrs. Betty P. Services Saturday." *The Bee*, June 21, 1957, accessed April 01, 2019, https://universityofnorthcarolinaatchapelhill.newspapers.com/image/46816138/?terms=%22pulley%22.

National Archives and Records Administration (NARA); Washington, D.C.; *Compiled Service Records of Confederate Soldiers Who Served in Organizations from the State of North Carolina*; Series Number: *M270*; Roll: *32*.

North Carolina, Marriage Index, 1741-2004. Charles P. to Bettie J., 18 March 1906, Northampton County, North Carolina.

North Carolina, Marriage Records, 1741-2011. Isaac W. to Julia B., 24 June, 1866, Sampson County, North Carolina.

North Carolina, Marriage Records, 1741-2011. Thos. J. to Missouri P., 19 August, 1879, Northampton County, North Carolina; Thomas J. was born in April of 1854 in North Carolina.

O'Rorke, Marjorie Lehman. *Haven on the Hill: A History of North Carolina's Dorothea Dix Hospital* (Raleigh: Office of Archives and History, 2010).

Rufus C., Application for Gravestone for Jacob C., War Department, 11 August, 1930.

Shorter, Edward. "Reflex Theory and the History of Internal Sensation" in *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Free Press).

Social Security Applications and Claims Index, 1936-2007, Thad O. P., type of claim: duplicate request, claim date: 11 March 1974.

Theriot, Nancy. "Diagnosing Unnatural Motherhood: Nineteenth-century Physicians and 'Puerperal Insanity'." *American Studies* 30, no. 2 (October 1, 1989).

Theriot, Nancy. “Women’s Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science,” *Signs* 19, no. 1 (Autumn 1993).

Trice, Calvin. "DeJarnette's Ugly, Complicated Legacy." The News Leader. August 31, 2017. Accessed April 01, 2019. https://www.newsleader.com/story/news/local/2014/03/22/dejarnettes-ugly-complicated-legacy/6753737/.

Wright, David. “Madness in the Archives: Anonymity, Ethics, and Mental Health History Research,” *Journal of the Canadian Historical Association* 23, no. 2 (2012).